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OVERSIGHT ON FAMILY PLANNING PROGRAMS UNDER TITLE X OF THE PUBLIC HEALTH SERVICE ACT, 1984

HEARINGS

BEFORE THE

SUBCOMMITTEE ON

FAMILY AND HUMAN SERVICES

OF THE

COMMITTEE ON

LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

CONSIDERATION OF THE REAUTHORIZATION OF TITLE X OF THE PUBLIC HEALTH SERVICE ACT, THE POPULATION RESEARCH AND VOLUNTARY FAMILY PLANNING PROGRAMS

APRIL 5 AND MAY 1, 1984

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OVERSIGHT ON FAMILY PLANNING UNDER TITLE X OF THE PUBLIC HEALTH SERVICE ACT, 1984

THURSDAY, APRIL 5, 1984

U.S. SENATE,
SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room SD-430, Dirksen Senate Office Building, Senator Jeremiah Denton (chairman of the subcommittee) presiding.

Present: Senators Denton, Nickles, and Grassley.

OPENING STATEMENT OF SENATOR DENTON

Senator DENTON. I want to welcome all the guests and witnesses to this hearing to consider the reauthorization of title X of the Public Health Service Act, the Population Research and Voluntary Family Planning Programs. This is the fifth hearing in 3 years that this Subcommittee on Family and Human Services has held on the workings of the title X program.

I have always had concerns about the efficacy and wisdom of some aspects of the Federal family planning program. Upon coming to the Senate, I became the chairman of the subcommittee that has oversight and authorizing responsibility for the title X, family planning law, and I must say candidly that, unfortunately, my investigations of the family planning program during the past 3 years have done little to allay my concerns.

I and many others still have serious concerns about the way the federally funded family planning clinics currently do business.

First, there is the widespread, as well as deeply held, conviction of many pro-life groups and others that some family planning clinics are doing little to reduce the incidence of abortion. I believe that those claims are justified.

It is not enough for this administration, or for any family planning provider, to point to the current prohibition against the use of funds "in programs where abortion is a method of family planning" as being completely satisfactory, when thousands of women are being referred to on-site abortion facilities run by title X grantees. Proabortion activities should not be sanctioned, even implicitly, by this title X law.

Those of us, I believe, including the President and the administration officials here today, Dr. Brandt and Mrs. Mecklenburg, who are concerned about the built-in bias toward abortion found in too many family planning clinics, must begin to explore ways to include among the providers of family planning services those groups that support alternatives to abortion.

Second, I and many other parents have strong convictions that most adolescents should not receive sexuality counseling and prescription contraceptive drugs or devices from a federally funded family planning center without the involvement of their parents.

In 1981, the family planning industry says that it served 1.5 million teenagers. Those 1.5 million patients accounted for nearly one-third of all women seen in 1981. Since 1978, the title X law has required that grantees provide services to adolescents. Some people believe that this policy is required on the basis of pure pragmatism. The logic runs that, since children invariably are going to become sexually active, federally funded family planning clinics have the responsibility to provide them with the means to avoid pregnancy.

My response to that argument is simple. We know that adolescents are notoriously poor users of contraceptives. We know that many adolescents will avoid seeking contraceptives early enough to prevent a first pregnancy. We know that many adolescents will continue to have early sexual relations until and unless our culture, role models, and advertised mores stop encouraging them.

Certainly, family planning clinics cannot be blamed for peer pressure and the messages conveyed by the media, nor can they be blamed for the loneliness and low self-esteem that undeniably are part of life for some adolescents.

On the other hand, teenagers certainly are not helped if the family planning profession is silent on the importance of self-control, or worse, presents to teenagers the justification that their decisions can legitimately be made solely on the basis of self-gratification—that flesh is all and spirit is nothing; that parents and guardians with a lifetime responsibility for the full human development of their children have no role in the important decisions that their children make about sex; that sexual intercourse has no relationship to the possible conception and birth of a third human being; and that that third human being is not as important or is not as equally entitled to life as the two parents, as each of the two parents.

In the case of all other youth problems, such as alcohol abuse, drug abuse, and juvenile delinquency, professionals have come to realize that parental involvement and the message of self-restraint are invaluable tools. I sincerely believe, without any apology whatever, that we in the Congress, those in the family planning community, and indeed, our society as a whole, must work together to send the factual message to our children that early sexual involvement creates risks, problems, and unhappiness that cannot be avoided by taking a pill. I do not believe that message is being thoroughly imparted.

In addition to the issues of inadequate restrictions on the promotion of abortions and the negative influences of simply providing teenagers with unencumbered access to contraceptives, we are here today to examine the administration of the title X law.

Even though I and many others have serious reservations about the need for the existing program, at all, I believe that we must scrutinize and seek to correct certain provisions and policies contained in the title X law. That means that we who criticize this program must be prepared to offer alternatives or ways to improve it.

Today, we will ask Dr. Brandt and Mrs. Mecklenburg to justify the administration's proposal to place the title X program in the primary care block grant, to answer criticisms of the management of the title X program, and to suggest needed changes in the current law.

I want to say at the outset that I do support the administration's reorganization of the family planning program and its effort to fulfill the congressionally mandated role for the Deputy Assistant Secretary of Population Affairs. I believe that many in the family planning community have demonstrated short sightedness and inconsistency in opposing the administration's enhancement of the DASPA position.

I am also concerned about the lack of interest and involvement by many of the critics of the family planning program who disdain to work with a sympathetic administration to remedy problems in family planning as quickly and as practicably as possible.

I plan carefully to review with all of the witnesses here today—and on other days, if necessary—the things that they believe need to be done so that the DASPA can effectively administer present Federal Government responsibilities under title X for meeting family planning needs.

We have invited the witnesses to discuss such topics as natural family planning, the provision of increased services to low-income women, infertility services, and State autonomy. Those are important subjects, and after the hearing, I want to be in a position to take the necessary actions to change the title X law for the better. If the Federal Government is going to be in the business of family planning, then our primary goal should be to help families plan in accordance with their own values.

We are pressed with business on the Senate floor, and in preparation therefor, aside from Senator Helms, whom we expect, Senator Grassley has told us that he will be here; Senators Weicker and Dodd have sent their apologies, because one has to serve as a chairman, and another is tied up, preparing to go on the floor of the U.S. Senate. Senator Nickles is reportedly going to be coming to the committee meeting this morning.

I see Senator Helms walking in. He could not have arrived at a more propitious moment. If you will permit Senator Helms to take his place at the witness table there, I would like to welcome him.

I appreciate my senior colleague from North Carolina in many, many ways—none more than for his commitment to protect the unborn, of his knowledge of this legislative process, in which he has helped me on innumerable occasions, making the difference between failure and success, and of his courage, which make him an effective lawmaker, and made him the man referred to in the 1980 preparations of our platform on the Republican side as "the conscience of the party."

Senator Helms, would you care to begin your statement?

STATEMENT OF HON. JESSE HELMS, A U.S. SENATOR, FROM THE STATE OF NORTH CAROLINA

Senator HELMS. Mr. Chairman, thank you. It is the other way around. This Senator comes to express his admiration for you and to express his gratitude that you are a Member of the Senate. You are a great Senator, you are a great American, and I have often said that a lot of folks have to present their credentials to demonstrate their love of this country. You have proved it in a most difficult way, and I am honored to be a colleague of yours in the U.S. Senate. I appreciate the opportunity to come here this morning to testify before this distinguished subcommittee.

I do not often make such a request, Mr. Chairman, and I do not intend to take very long in my remarks. But I do feel obliged to offer testimony as part of my responsibility to the people whom I am privileged to represent. I think it is time that we faced the facts about one of the most misguided programs in the Federal Government, that being title X of the Public Health Service Act. Since it was first authorized in 1970, title X has cost the American taxpayers $1.5 billion, approximately.

But that expenditure is inconsequential compared to the frustration the program has caused. A distinguished constitutional authority recently said to me that $1.5 billion in the hands of terrorists could not have inflicted the long-term harm to our society that these title X expenditures have.

This program was begun as family planning assistance for low-income families. It sounded commendable. Most programs do. Its stated purpose—and I emphasize the words, "its stated purpose"—was to assist poor couples to plan their families. As with many other programs with humanitarian intent, Congress established title X and then left it in the hands of the Federal bureaucracy. That is when things went haywire. Within a few years, most title X funds were going to a national network of interlocked organizations. This totally politicized network today engages in lobbying, pressure politics, and litigation against Federal and State governments. Increasingly, this network has aimed its programs not at families, but at minors, teenagers in high schools, junior high schools. It has injected its propaganda, much of it far too offensive to discuss in this public forum, into even the elementary schools of this Nation. Yet, year after year, the Congress has paid scant attention to what title X grantees were actually doing with the public's money.

Our most recent chance to take a look at this situation came in 1981, when the authorization for title X expired. But nothing happened.

So, let us be candid at least with ourselves about the reasons. The perpetuation of this program for 3 years was the price extracted from the administration by certain Members of Congress in exchange for adoption of the administration's block grant proposals in health care, and this was a heavy price for the families of American to pay. They should not be asked to pay it again. This time, there should be no behind-the-scenes deals to protect title X from public scrutiny and parental outrage. Let's get the facts on the record, and then let the people judge for themselves.

The first is that title X is a sacred cow in the Federal herd. The Congress has tolerated abuses in title X which we would never allow in any other program. Two investigations by the General Accounting Office have been critical of title X's waste, fraud, and abuse, and nothing has been done by this Congress to remedy the situation.

Another fact about title X is that its grantees use the taxes paid by American mothers and fathers to give their children contraceptives, including prescription drugs and devices, without the consent, without even the knowledge, of their parents.

Now, Mr. Chairman, a physician cannot pierce the ears of a teenage girl without parental approval. Yet, title X grantees use public funds to distribute potentially dangerous drugs and devices to minors without even parental notification. If a young girl suffers a severe physical reaction, her parents, of course, will be legally liable for her medical bills.

So I ask, shouldn't the parents at least know what kinds of drugs she is being given, and by whom? That question must be faced not only by this committee, but by the full Senate, and I will be asking that question on the Senate floor, to provide all Senators an opportunity to give their respective answers to it.

Another question to which we must respond is whether title X services, supposedly for low-income families, should go to children of rich families. Now, title X has turned out to be welfare for affluent teenagers. Why? Because the HEW bureaucracy in years gone by deliberately distorted the program's authority to serve low-income families. Instead, they allowed title X grantees to determine a boy's and girl's eligibility to receive free contraceptives on the basis of the child's personal income, rather than the family income. So, when a banker's daughter or a millionaire's son comes to a title X clinic, they, of course, qualify as poor persons, since they have no income of their own, and they can receive, and do receive, free contraceptives of their choice, all paid for, of course, by the taxpayers, including, I might add, the exemplary youngsters who hold down jobs after school and on weekends to help their families try to save for the future.

So, I think the Senate owes the American people an explanation of why we have tolerated this situation, and I think we owe it to ourselves to go on record for or against it. And floor debate on title X will give us that opportunity to stand up and be counted, one way or another.

A particularly offensive aspect of title X is the way it has been distorted into an annual subsidy for the abortion lobby. Now, when the program began, abortion was illegal in this country. The sponsors of this program assured their colleagues that abortion would never have a role in the program; there would never be a connection, they said. So what has happened?

Today, those assurances are mocked by the fact. Most title X funds go to organizations which engage in abortion, promote abortion, lobby for abortion, litigate about abortion. If the advocates of title X want it to continue, then I invite their support in returning the program to its original intent. I ask their support in building a wall of separation between family planning programs and the abortion business. And I need their support for legislation that would prohibit the use of title X funds by any organization which in any way engages in abortion or abortion referral or abortion counseling, abortion lobbying, abortion advertising.

Mr. Chairman, a little more than 1 year ago, this committee brought to the attention of the Secretary designate of Health and Human Services the unpardonable political lobbying engaged in by Planned Parenthood and its affiliates, which constitute most of the title X network. And members of this committee showed the Secretary designate a full newspaper ad, very expensive, which those organizations were using in their campaign against certain legislation. Members of this committee asked the Secretary designate what her Department, which administers title X, had done to stop these abuses, or what it planned to do to prevent them in the future. More than 1 year has passed, and absolutely nothing has been done; absolutely nothing has been done to prevent the public's money from being poured into political lobbying by Planned Parenthood and other title X grantees. Now, if the Department of Health and Human Services will not do its duty, then let us at least do ours, by amending this reauthorization to ban completely all lobbying by any title X grantee. I submit that this is the very least that we owe to the taxpayers of this country.

As I pointed out, the title X program desperately needs thorough reform. It needs a parental consent requirement, a bona fide low-income eligibility requirement; new safeguards against grantee fraud and abuse, and total severence from the abortion dealers. And even all those reforms, however, leave us with a fundamental question about title X: What is it for, and does it work? Does the establishment of a title X family planning clinic in a community have a beneficial effect, or does it worsen such social pathologies as venereal disease and teenage pregnancy and the abortion rate?

Certainly, over the life of the title X program, we have seen no reversal in these social problems, and no one can deny the fact that title X does indeed subsidize teenage sexual activity. It is on the basis of this fact that some argue title X directly and positively increases the incidence of venereal disease, teenage pregnancy, and abortion.

So at a minimum, title X tends to create an atmosphere in which teenage promiscuity is viewed as normal and acceptable conduct, and which in turn fosters the very problems we are trying to solve.

Mr. Chairman, 20 years ago, there were a great many well-intentioned notions about the way Federal programs, presumably, could alter and improve personal conduct, and government trying to make people economically productive, for example, by guaranteeing them economic security. It has not worked; it will never work.

Title X remains today a bastion of the specious reasoning of the 1960's, repudiated in economics, in law, in education, and welfare; in virtually all areas of public policy, the outdated social engineering of the 1960's still flourishes in the title X program. It still repudiates parental rights, familiar responsibility, and traditional morality.

It still throws explosive fuel on the raging fire and disavows responsibility for the consequent explosion, which is to say, it deals with a moral breakdown in society by fostering, even encouraging, permissiveness and a lack of standards. That is not the way that title X was originally sold to the American people. It was supposed to be family planning—that is, for married couples. But in title X, family planning is now a euphemism for the distribution of millions of dollars a year in contraceptives to boys and girls and anyone else who happens to want them, and I do not believe that the parents of America want us to continue that intellectually and ethically bankrupt enterprise. I do not believe the young people of America should be misled and betrayed by their elders with a false view of life, a distorted view of human relationships, and a destructive set of secular values. That is what title X is all about.

I think, Mr. Chairman, it is time for us in the Congress at least to discuss it openly and honestly, fully, and vote on each one of these controversial aspects. Let each of us take our stand. And even that would not bring a remedy overnight, but it will be the first step in bringing the people of this country into this title X fight. And their involvement, I am convinced, will ultimately turn the tide against what title X is doing to their children and to our communities.

Mr. Chairman, I thank you so much for the opportunity to appear this morning.

Senator DENTON. We sincerely thank you, Senator Helms. I know you are busy. I wonder if you would mind my reinforcing just one thing you said. You referred to the American public wanting parental involvement. I do not think we can overemphasize the fact that, although the recent decision not to pursue the parental consent notification regulation imposed on the part of HHS may have a good argument because it was based on the validity of the lack of expression of congressional mandate to that effect.

Senator HELMS. Exactly.

Senator DENTON. I must say that the ruling was arrived at in an environment created by the media and those who are propounding no parental involvement, or no parental consent or notification. The environment was composed of a belief that the public very heavily opposed the regulation. A Gallup poll was conducted on that subject, Senator Helms, and the question was:

> Would you favor or oppose a regulation that would require Federally-funded family planning clinics to notify parents when the clinic prescribes prescription birth control drugs and devices, such as the pill, to female children under the age of 18?

The answer to that question on a national basis, irrespective of gender or age, was 54 percent favored the regulation, 40 percent opposed, and 6 percent did not know. In the age groups in which the motherhood or fatherhood of teenage children were relevant, considering the age of the parents—for example, in the age group 30 to 49, 55 percent favored, 38 percent opposed; over 50, it was 60 favoring and 33 percent opposed. And yet, almost without exception, even conservative columnists were deluded into the belief that the public was against that regulation. So, as usual, you have put your logical finger on the essence of the matter, and we greatly appreciate your appearance here this morning and your words.

I want you to know, it has not been because of lack of effort that something has not been done about this, but it has been a rather lonely effort. There have been groups, so-called pro-family groups, who could have done a bit more, I think, in trying to bring this issue before the public. Until the public hears the issue, as they did through the Gallup poll, I do not understand how they are going to express their will. And on the floor, they are just as uninformed about this as they are about certain other things, unless they will come to a hearing, or unless the liberal media will publish the results of hearings.

Senator HELMS. Or unless they are otherwise contacted and advised of an opportunity to stand up for what they believe. I believe there are organizations in this country, Mr. Chairman, who will assist you in the great and noble effort that you have put forth in this regard. You are exactly right—you have not had much help. But I believe that in the coming weeks, you will see helping hands extended to you, and I know that that will be very gratifying to you, because as you have said, it is lonely sometimes to try to stand for a cause around this place, but eventually, from my own experience, I have a very high regard for the judgment and the principles of the American people, once they are given the information.

As for the news media, even our conservative brethren among the columnists, I guess it is like Sam Ervin said one time, "They are always positive and sometimes correct."

Thank you, Mr. Chairman.

Senator DENTON. Thank you, Senator Helms. We will now receive for the record a statement from Senator Dodd.

[The prepared statement of Senator Dodd follows:]

STATEMENT OF SENATOR CHRISTOPHER J. DODD
SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES HEARING
APRIL 5, 1984

MR. DODD: MR. CHAIRMAN, I WOULD LIKE TO COMMEND DR. JOAN BABBOT FOR APPEARING BEFORE THE SUBCOMMITTEE THIS MORNING. A PHYSICIAN TRAINED IN PEDIATRICS AND PUBLIC HEALTH, SHE IS ESPECIALLY QUALIFIED TO TESTIFY ON THE MERITS OF THE TITLE X PROGRAM AND ITS REAUTHORIZATION.

DR. BABBOT IS NOW THE EXECUTIVE DIRECTOR OF THE PLANNED PARENTHOOD LEAGUE IN MY STATE OF CONNECTICUT, WHICH SERVES CLOSE TO 45,000 WOMEN IN 19 CLINIC SITES. SHE HAS DEVELOPED A SPECIAL PROGRAM FOR PARENTS SEEKING TO ANSWER THEIR CHILDREN'S QUESTIONS ABOUT SEX ENTITLED "ARE YOU AN ASKABLE PARENT?" WHICH SHOULD BE OF SPECIAL INTEREST TO THIS SUBCOMMITTEE.

I AM CERTAIN THAT DR. BABBOT'S TESTMONY WILL BE A MOST VALUABLE ADDITION TO THIS MORNING'S HEARING AND I THANK HER FOR DELIVERING IT.

Senator **Denton**. We have Dr. Brandt and Mrs. Mecklenburg, assuming their places at the table. While they are, I would like to make one request. We have quite a few witnesses, and in the interest of time and fair hearings to each, a proportionality of advocacy, if you will, I am going to have to ask for a strict 5-minute time limit for oral summaries. Each witness, although there might be two together with one advising the other, each witness unit, if you will, will be restricted to that strict 5-minute time interval. So I will ask you to note the red light, and when it illuminates, please, bring your presentation to a quick close.

Again, Dr. Edward Brandt, Jr., Assistant Secretary for Health at the Department of Health and Human Services, and Mrs. Marjory Mecklenburg, Deputy Assistant Secretary for Population Affairs at the Department of Health and Human Services.

Dr. Brandt, please proceed.

STATEMENT OF EDWARD N. BRANDT, JR., M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND MARJORY MECKLENBURG, DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS

Dr. **Brandt**. Thank you very much, Mr. Chairman.

I am pleased to be here today to discuss the Title X family planning program.

Today, family planning is a mature program, well-established in each of the States of this Union. As such, it is appropriate to shift administrative responsibility from the Federal Government to the States, thus permitting them the maximum flexibility in tailoring these efforts to their citizens' needs.

We will shortly be submitting legislation to the Congress to include the family planning program in a primary care block grant.

The basic program for the delivery of family planning services involves the awarding of grants by regional offices to public and private nonprofit entities to establish and operate voluntary family planning projects. Since the enactment of title X, Congress has added the requirement that natural family planning, infertility services, services for adolescents, and family involvement must be covered by title X.

Under the legislation, title X-funded programs must assure that priority is given to persons from low-income families. Since the beginning of the program, the use of these funds for abortion has been prohibited, and title X projects may not provide abortions as a method of family planning.

There are a number of important activities contained in that legislation in our total program, in addition to services, and I have outlined those and the funding in my testimony.

To improve our administration of the family planning program and to bring the organizational structure into closer conformance with the purpose of title X, Secretary Schweiker ordered the transfer of the operating functions of the family planning program to the Deputy Assistant Secretary for Population Affairs approximately 1 year ago.

Because of this, policy setting and implementation are no longer separated.

The Office of Population Affairs has been reviewing all aspects of the family planning program, seeking to help grantees improve the quality and outcome of the services provided. Part of this process has been an extensive interaction with the title X grantees to provide them with greater opportunity to share their concerns and to express their views.

The 1984 family planning services allocation was developed with information gained through the 10 regional grantee meetings. In fact, the three factors used in the alllocation—namely, stability of funding, women-in-need, and performance—were the major issues identified.

We have begun to use the peer review system of the NIH to decide who will receive service delivery improvement research grants. Nine of these are currently funded.

We have launched a new effort to improve the quality and use of existing family planning data. We are now undertaking collection, analysis and dissemination of a number of important items of information, and I would like to submit for the record, with your permission, a progress report on our efforts thus far.

Senator DENTON. Without objection, that will be included in the record.

Dr. BRANDT. Thank you, sir.

Parents should, and most parents do, play an important role in the lives of their children during their formative years. Each title X grantee has been given guidance to ensure that they have a number of parental involvement elements in their programs, and I have identified the specific ones.

I believe the family planning program, Mr. Chairman, is now sufficiently well-established to turn over the bulk of administrative responsibility to the States. To accomplish this, the administration proposes including the program in the primary care block grant. Integrating the family planning program with other primary care activities in the block grant offers a number of medical advantages. First, it permits the promotion of good health practices by women who are becoming sexually active, including such things as immunization against rubella, counseling regarding the health effects of lifestyle choices, proper spacing of pregnancies, and appropriate care for those women with chronic diseases such as diabetes, hypertension, and others. Second, women for whom contraceptive methods fail are already in the system for care, permitting prenatal care to be implemented promptly and early. Third, there can be early implementation of counseling as to pregnancy, and finally, implemention of follow-up on the child once it is born to ensure good well-baby care, immunizations, and other factors essential to the baby's health.

We believe the block grant approach will permit States to design a primary health care delivery system best-suited to the particular needs of its citizens. Such flexibility is essential if States are to be responsive to their citizens' primary health care needs.

Mr. Chairman, the administration asks that you and your subcommittee look favorably at the block grant approach for family planning as part of primary care, for I believe we can be optimistic about the future of family planning services under the primary care block grant.

That concludes the summary of my statement, Mr. Chairman, and Mrs. Mecklenburg and I are prepared to answer questions.

[The prepared statement of Dr. Brandt and responses to questions submitted by Senator Denton follows:]

STATEMENT

BY

EDWARD N. BRANDT, JR., M.D.
ASSISTANT SECRETARY FOR HEALTH

BEFORE THE

SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES
OF THE
COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

APRIL 5, 1984

Mr. Chairman and members of the Subcommittee:

I am pleased to be here today with Mrs. Marjory Mecklenburg, Deputy Assistant Secretary for Population Affairs, to discuss the title X family planning program.

Today family planning is a mature program well established in each of the States. As such, it is appropriate to shift administrative responsibility from the Federal government to the States, thus permitting them the maximum flexibility in tailoring family planning efforts to their citizens' needs. This Administration supports the transfer of the family planning program to the States and will very shortly be submitting legislation to include the family planning program in the Primary Care block grant. I will address the programmatic advantages of this proposal at the end of my testimony.

I would like first to take this opportunity to discuss the current family planning program under title X of the Public Health Service Act. the program contains four components: family planning services; training; development of information and education materials; and service delivery improvement research.

The basic program for the delivery of family planning services involves the awarding of grants by the Public Health Service Regional Offices to public and private non-profit entities to establish and operate voluntary family planning projects. When the title X legislation was enacted, Congress identified the need for a national program to assist in making "family planning services readily available to all persons desiring such services." Since the enactment of title X, Congress added the requirement that natural family planning, infertility services, services for adolescents, and family involvement must be covered by title X projects.

Family planning projects are required to provide a broad range of acceptable and effective methods and services. These services include medical and social services counseling to help women decide which method of family planning, if any, to choose. It is also important to note that acceptance of family planning services must be completely voluntary. Oftentimes, a visit to a family planning clinic is the first place women receive formal medical care including a physical examination and screening for cancer, anemia, high blood pressure, and sexually transmitted diseases.

For the current fiscal year, $132.8 million are available for family planning services that will serve an estimated 3.7 million persons (about one-third of whom will be adolescents). The program currently has 88 grantees that provide services at over 4500 clinic sites. In FY 1983, in 33 States, the State Health Department was the sole title X grantee, and in 10 other States, a State agency was one of several title X grantees.

Under the legislation, title X-funded programs must assure that priority is given to persons from low-income families. As defined by the regulations, persons from low-income families may not be charged for services.

Preliminary data from 1983 indicate that approximately 3.2 million women with incomes below 150% of the Federal poverty standard received services through the program. This group represents about 86% of the total title X users. Patients with income above this poverty standard are charged for services on a sliding scale.

Since the beginning of the program, the use of title X funds for abortion has been prohibited. Title X projects may not provide abortions as a method of family planning.

In addition to family planning services, I would like to briefly touch on the other components of title X. There are three other important activities funded in the title X program. In FY 1984, $3.1 million will be spent to provide training for personnel to carry out the family planning services which I have just described. $530,000 will be spent to develop and make family planning information and educational materials available to all persons desiring them. Under the law, informational and educational materials used in title X projects must be suitable for the community and population for which they are used. It is required that a local advisory committee review and approve these materials.

The title X legislation also provides for research designed to assist in improving the delivery of family planning services. In FY 1984, $2.2 million will be spent for this service delivery improvement activity.

The Deputy Assistant Secretary for Population Affairs (DASPA) and the Office of Population Affairs (OPA) were created when title X was enacted on December 24, 1970. For many years the family planning constituency has urged the Department to operate the DASPA office with sufficient staff to carry out its role. Prior to this Administration, all OPA positions were eliminated. I am pleased to be able to say that the office is now fully restored.

To improve our administration of the family planning program and to bring the organizational structure of the title X program into closer conformance with the purpose of title X ~~my predecessor~~ Secretary Schweiker, ordered the transfer of the operating functions of the family planning program to the DASPA a year ago. That change makes good sense and should have been done long before.

Because of this reorganization, policy setting and implementation are no longer separated. Another benefit is that three closely related programs with much in common--family planning services, population affairs, and adolescent family life--have been brought together. As a result, we have lessened the need for coordination. Having policy and operations and the three programs together also achieves improved staff interaction.

The OPA staff has been reviewing all aspects of the family planning program seeking to help grantees improve the quality and outcome of the services provided. Part of this process has been an extensive interaction with the title X grantees to provide them with greater opportunity to share their concerns and to express their views, on a wide variety of issues in family planning today.

For example, last spring and summer, the program met with grantees in every region to discuss such matters as the title X national allocation methodology, services delivery improvement (SDI) research, and contraceptive costs. These meetings were useful and we intend to sponsor them each year. Meetings have also been held that focus on family planning services research. Each region was asked to establish a group of title X grantees to provide ideas for research that would address existing service problems or opportunities to enhance services. In addition, a small group of service providers from across the country was brought together to share their perspective on research to the Office of Family Planning (OFP) staff. The program intends to use similar mechanisms to address a variety of issues and, by rotating the participants, give all grantees access to the Federal family planning process.

Family Planning Allocation

The FY 1984 family planning services allocation was developed with the information gained through the ten regional grantee meetings. The three recurring themes raised at these meetings--stability of funding, women-in-need, and performance--are the principal components of the FY 1984 formula.

$500,000 has been reserved from each regional allocation for National Priority Projects in five subject areas:

- o Infertility Services
- o Natural Family Planning
- o Family Involvement
- o Male Involvement
- o Regionally Identified Areas of Concern

National Priority projects are not a new phenomenon in the title X program. In several previous years funds were allocated among the regions for special initiatives or national priorities, both on an equal basis and on a proportionate basis according to selected criteria.

This year, as in the past, priority projects are for services title X must cover but that grantees have found difficult to implement. Regions are working with title X grantees to develop projects in these areas that will demonstrate innovative approaches for potential use and adaptation by grantees throughout the country.

Service Delivery Improvement

In fiscal year 1983, we used the highly respected peer review system of the National Institutes of Health (NIH) to decide who would receive service delivery improvement research grant awards. This change was made to insure that only high quality research is conducted and that it focuses on topics to help service providers deliver services more effectively and efficiently. Some of the areas for study identified in last year's competition were:

- the factors influencing family planning clinic patients who desire family planning but who "drop out" of clinics;
- the managerial and organizational factors involved in providing effective and efficient services to poor women in a family planning program and its clinics; and
- the nature of current infertility problems among poor women.

Nine service delivery improvement projects are currently funded. We anticipate useful results. We will use the NIH peer review process again this year. We followed the peer review process exactly and funded these projects for a total investment of $801,619 in FY 1983.

But no matter how solid or useful research may be, it will be of little benefit if it is not used. To insure that service providers, researchers, and policy makers have access to these results, the Office has taken another step. All SDI research grantees are required to deposit their data in a public use data archive, thereby insuring wide availability of the results and the data upon which the conclusions were based. In addition, a vigorous program of dissemination of the information gained by the research program will be directed to family planning service providers so that they will have the maximum benefit from this important research activity.

Data

Information about the characteristics of family planning clinic patients served by organized family planning programs has been essential for administrators and policy makers to have since the inception of the title X family planning program in 1970. Initially, the task of collecting these data was entrusted to the National Center for Health Statistics. Since 1977 various efforts have been undertaken to collect and analyze the data including voluntary efforts by family planning organizations.

We have launched a new effort to improve the quality and use of existing family planning data. The Office of Population Affairs (OPA) is now undertaking the collection, analysis, and dissemination of the (1) number of women at risk of unintended pregnancy; (2) number and characteristics of patients served by organized family planning programs; (3) number of low income women served by private physicians; and (4) sources of funding for family planning services provided by organized programs. Several statisticians and demographers in OPA have this effort well underway. I am submitting for the record, documentation of our progress thus far.

The collection, processing, and analysis of these data by the Office of Population Affairs has several advantages. The availability of primary data allows for preliminary analyses and increases the number and variety of analyses that can be done. The information gained will be published and public use tapes will be deposited in a public data archieve thereby making the information available to a broad audience of researchers, policy makers, service providers, and others interested in family planning issues.

In addition to collecting and analyzing organized family planning data, the Department collects management data on title X programs under a system called the Bureau Common Reporting Requirements. Grantees' views on the reporting system were obtained at the ten regional meetings, and a technical advisory group of family planning professionals and data experts was called together to give guidance on this subject.

Information and Education Materials

One of the primary thrusts of our activity in the Information and Education area is the development of materials for parents. Over the years the Government has produced enormous amounts of materials on all topics, including adolescent sexuality.

OFP has funded a review of materials on adolescent sexuality produced under Federal sponsorship over the past ten years to assess these materials from the view point of discouraging premarital adolescent sexual relations, and encouraging parents to impart their values to their children and provide them with information regarding sexuality. The goal is to identify materials that can be used with little or no change, or that need updating and substantive additions, as well as identifying those areas in which new materials need to be produced. One area in which the need for new material is already known is bilingual, bicultural parental involvement training manuals based on Hispanic cultural family values. These manuals will be used by providers of family planning services to help Hispanic parents and extended family members to communicate their values and impact information to their children. This activity is already underway and will be completed by the fall of 1984.)

Family Involvement

Parents should, and most parents do, play an important role in the lives of their children during their formative years. Given a responsibility to promote maximum communication between parents and their children, the

Department's activities include program and policy choices that involve parents in decisions to the fullest extent possible; and informational and educational material to encourage communication in these vital areas.

In addition to the parental involvement effort in information and education I described earlier, each title X grantee has been given guidance to ensure that they have the following parental involvement elements in their program--a policy which supports the involvement of parents in the delivery of family planning services to their children and specific objectives which will increase the involvement of parents of the adolescent clients in their clinics. In addition, a parental involvement seminar is being provided for all governing board or advisory council members of family planning clinics.

1985 Block Grant Proposal

Mr. Chairman, I believe that the family planning program is now sufficiently well established to turn over the bulk of administrative responsibility to the States. To accomplish this, the Administration proposes including the program in the Primary Care block grant. Integrating the family planning program with other primary care activities in the block grant offers a number of advantages:

- Promotion of good health practices by women who are becoming sexually active, including immunization against rubella, counseling regarding health effects of lifestyle choices, proper spacing of pregnancies and appropriate care for those women with chronic disease such as diabetes, hypertension, sexually transmitted diseases, and genetic illnesses such as sickle cell disease;
- Women for whom contraceptive methods fail are already in the system for care; prenatal care can be implemented promptly and early;
- Early implementation of counseling as to pregnancy; and
- Implementation of follow-up on the child once it is born to ensure good well-baby care, immunizations, etc.

Perhaps most important, the block grant approach will permit States to design a primary health care delivery system best suited to the particular needs of its citizens. Such flexibility is essential if States are to be responsible to their citizens' primary health care needs.

I have confidence that the States will be very supportive of family planning and will continue to provide the necessary high quality family planning services that have been provided to low income women. Currently 33 of the 57

State or territorial agencies are the sole title X grantees in their areas. In another ten States where there are more than one title X project, a State agency is one of the title X grantees. Finally, in seven other States, including California, State agencies have had substantial experience in administering family planning services funded through Federal programs like the title XX Social Services Block Grant or through State resources.

Mr. Chairman, the Administration asks that you and your Subcommittee look favorably at the block grant approach for family planning for I believe we can be optimistic about the future of family planning services under the Primary Care block grant.

DATA ON FAMILY PLANNING, 1983

Collection and Analysis

During 1984 the Office of Population Affairs will collect and analyze data on family planning services in the United States. Four types of data will be collected and analyzed: data on women in need of family planning services, data on family planning patients served by private physicians, data on patients served by organized family planning services, and data on funding patterns for organized family planning services. Although these four types of data are analytically related, each requires separate operations for data collection and manipulation. Each set of operations will be discussed below.

Women in Need of Family Planning Services

Following the definition developed in earlier years, a woman will be considered at risk of an unintended pregnancy, and therefore in need of family planning services, if during 1983 she was (1) fecund (able to conceive and carry a pregnancy to term), (2) sexually active, and (3) neither intentionally pregnant nor trying to conceive. In theory, if a woman simultaneously met all three of these conditions at _any_ time during 1983, she was in need of family planning services in 1983, even though she may not have met all conditions for a large part of the year.

The ultimate objective is to estimate the number of women in need for each county of the United States; however, data on the three components of the need definition--fecundity, sexual activity, and pregnancy intentions--are not available for small areas. Therefore, a synthetic estimation procedure will be used: first, we will estimate the proportions of women with each of the three need conditions for selected subgroups of the _national_ population; then we will estimate the number of women in each subgroup for each _county_; finally, we multiply the number in each county subgroup by the product of the three _national_ estimates of proportions _for the same subgroup_. The resulting product will be an estimate of the county's subgroup in need of family planning services. By summing the numbers in need over subgroups, the number in need in each county will be estimated. The county estimates can then be aggregated to State and Regional estimates.

It should be noted that this procedure assumes that fecundity, sexual activity, and pregnancy intentions are statistically independent; in other words, it assumes that whether or not a woman is fecund has no effect on her sexual activity, and her sexual activity has no effect on her pregnancy intentions. This is not an accurate assumption, of course, but given the nature of the data available to make the estimates, it is a necessary assumption: if existing samples were used to estimate proportions who were *simultaneously* fecund, sexually active, and avoiding conception, they would be statistically unreliable. While the effect of this assumption cannot be determined exactly for detailed subgroups of the population, some idea of the effect can be obtained by comparing *national* estimates of need based on multiplication of the three factors, with estimates based on direct tabulation of the proportions who exhibit all three conditions simultaneously, and such comparisons are planned.

In prior years the national estimates of fecundity, sexual acitivity and pregnancy intentions were made using a variety of data sources. For instance, to estimate the sexual activity of currently married and formerly married women, the National Survey of Family Growth, Cycle II was used; and for never married women, the National Survey of Young Women was used. This eclectic approach was necessary because there was not single data source which contained enough information to estimate all three need conditions for all women. Now, however, the National Survey of Family Growth, Cycle III (NSFG) is available. Conducted by the National Center for Health Statistics in 1982, the NSFG is based on a national sample of *all* women, ever married or never married, aged 15 to 44 years; and it contains the data needed to estimate fecundity, sexual acitivity, and pregnancy intentions. Thus, it is possible for the first time to estimate need for family planning services from a *single* data source.

There are several advantages to using this single data source. First, when several different data sources are used, there are inevitabe differences in procedures and definitions which introduce unmeasurable biases in the combined estimates; by using a single data source, the differences and biases are largely eliminated. Second, when using different data sources, it has not been feasible to estimate sampling errors of need estimates; by using a single source, it is feasible to estimate sample errors, giving us some measure of the statistical reliability of the estimates for the first time. Third, the computation of the estimates from a single source will be much more straight forward; this will not necessarily reduce the time and effort needed to make the estimates (just as many tabulations and computations may be required), but it will make the procedures understandable and accessible to a larger audience of policy makers and program administrators. For these reasons, we will use the National Survey of Family Growth, Cycle III to estimate the proportions of women in various national subgroups who are fecund, sexually active, and neither intentionally pregnant nor trying to conceive.

By prior arrangement with the National Center for Health Statistics, the Office of Population Affairs has obtained an advance copy of the NSFG data tape, and preliminary tabulations of fecundity, sexual activity, and pregnancy intentions have been completed, according to age, race, metropolitan-nonmetropolitan residence, poverty level income, and marital status. These categories are those which will be used to make county level estimates. These tabulations are preliminary, of course, and will need much further refinement, but they have demonstrated the general feasibility of the approach.

Once the estimates of fecundity, sexual activity, and pregnancy intentions are completed, they must be applied to estimates of county populations classified according to the same variables mentioned in the preceding paragraph. The basic tabulations of county populations by those variables were done by the Bureau of the Census using the 1980 Census of Population. Those population figures were updated to 1981 by the Alan Guttmacher Institute for its 1982 report of family planning, and will be updated to 1982 using the same estimating procedures.

Family Planning Patients Served by Private Physicians

In previous years, the principal source of data on use of private physicians for family planning services was the National Ambulatory Medical Care Survey (NAMCES), conducted by the National Center for Health Statistics in 1980-81. The NAMCES is based on a national sample of office-based physicians who report on a sample of office visits. If the patient's stated reason for a visit was "family planning," or if therapeutic services for family planning were provided, NAMCES classifies the visit as a family planning visit. Data on such visits have been used to estimate the volume of family planning services provided by private physicians.

Although the NAMCES data were the best available, they did present some problems. For instance, the data are for visits, not women; because women may make more than one visit in a year, data based on visits overestimate the number of women served to some extent. Also, the NAMCES did not collect information on poverty level income and other subgroup characteristics for which estimates of use are needed; this shortcoming was overcome by distributing the NAMCES cases according to distributions from other data sources, a procedure whose validity depends on some untestable assumptions.

Because of these shortcomings of the NAMCES (for this particular purpose), and because of the recent availability of the NSFG, Cycle III, we plan to use the NSFG to estimate use of private physicians for family planning services. The NSFG asked a series of questions about the types of service received in the last year, and the provider of those services. It also asked questions about income and the other subgroup characteristics for which service use estimates are needed. Thus, it will be possible to make estimates of women's use of private physicians for family planning services, according a wide range of characteristics. Furthermore, because the NSFG obtained considerable detail on types of service and providers of service, it will be possible to experiment with different definitions, and thus refine the measurement of private physician services.

As noted earlier, a preliminary version of the NSFG is already in use at the Office of Population Affairs, and some tabulations of private physician family planning services have been produced. Also, we have obtained from NCHS the tabulations of family planning services from the NAMCES; we plan to compare them with the new tabulations from the NSFG to investigate the effects of this change in data sources and definitions.

Patients Served by Organized Family Planning Services

The objective of this activity is to estimate the total number of women served by organized family planning services ("clinics"), according to selected characteristics of those patients, such as age, poverty level income, and race. Statistics of this type are not available through any ongoing data system of the Federal government. (They were once collected by the National Center for Health Statistics in its National Reporting System for Family Planning Statistics, but that data system has been discontinued.) Instead, an _ad hoc_ data collection is underway which will proceed through several steps.

For family planning clinics which are supported by Title X funds, the beginning point will be the directory of family planning clinics maintained by the National Clearinghouse for Family Planning, an activity supported by the Office of Family Planning through a contract. The directory contains a complete list of clinics supported by Title X funds, and many other clinics supported by other Federal funds. Most of the clinics supported by Title X funds participate in a centralized, automated data system, which can provide statistical information on patients for all participating clinics. Letters have been sent to the officials responsible for the automated data systems asking them to share the statistics on patients which they have compiled. Similar letters were sent to Title X grantees not included in automated data systems.

Pending receipt of responses to those letters, the Clearinghous has initiated efforts to extend its coverage of family planning clinics. It has contacted other Federal agencies which support family planning for lists of their clinics. It has also sent letters to all of the clinics in its present directory asking them to identify any non-Federally funded clinics in their communities. We expect these efforts to result in a list of clinics which includes virtually all of the Federally funded clinics (usually estimated to be about 85% of all clinics) and a large part of the non-Federally funded clinics.

As the responses to our letters to automated data systems arrive. they will matched against the expanded directory list.

Because the automated systems may include some non-Title X and non-Federal clinics, that match is necessary to avoid duplicate counts. Letters will then be sent to any clinics not covered by the automated systems or non-automated Title X requests, again asking that they share data which they have compiled on patients and their characteristics.

To assemble these data from different sources, cross-check the several lists of clinics, and then aggregate the data into national estimates is a large-scale undertaking. We are designing intake and tracking procedures to insure that letters are followed up, responses are edited for completeness, duplication is avoided, and quality control is maintained. Because the National Clearinghouse on Family Planning maintains lists of clinics and mass mailing capabilities, we have made it an integral part of our plans for this part of the data activity.

Funding Patterns for Organized Family Planning Services

The bulk of funding for family planning clinics is from Federal sources: Titles X, IV, XIX, and XX. Data for previous years on funding from those sources is available from reports prepared by the Alan Guttmacher Institute. For the more recent period, information on funding at the State level will be obtained by contacting the appropriate agencies in each state. Funding information from Title X supported clinics will be obtained from project reports of Title X grantees. As the Alan Guttmacher Institute has noted, "it is extremely difficult to obtain" firm data on funding, because appropriations and accounting procedures do not allow for the disaggregation of the family planning service component of many programs. Nevertheless, by following the procedures used in earlier reports we expect to produce estimates which will reveal approximate levels and trends in funding patterns.

Supplementary Analyses

The availability of in the Office of Population Affairs of these several basic data sets will permit some policy-relevant analyses which have not been possible previously, analyses which go beyond those anticipated as part of the basic report described above. For instance, by combining data on women in need or patients characteristics for small areas, with data from nationally representative data sets on individual women, such as the National Survey of Family Growth, it will possible to investigate quantitatively the relationships between the family planning needs of communities, the services they receive, and the family planning success of individual women.

FAMILY PLANNING DATA

There are four sets of statistical information collected on family planning and low-income women. While the methods of collection, the specificity of the data and the reliability have varied over time, the basic categories of the information assembled are the same. The four types of data are: (1) women at risk of unintended pregnancy; (2) number and characteristics of patients served by organized family planning programs; (3) number of low income women served by private physicians; and (4) sources of funding for family planning services provided by organized programs.

1. Women at risk of unintended pregnancy and with incomes at or below 150% of the poverty level (women-in-need) will be based on demographic data from the 1980 census updated with the Current Population Surveys of Income and Poverty, and then adjusted according to estimates of sexual activity, fecundity and unintended pregnancy. The most recent, reliable and comprehensive estimates of sexual activity, fecundity and unintended pregnancies for married and single women and adolescents are obtained from the National Survey of Family Growth (NSFG) Cycle III. OPA already has an advance copy of this data set.

2. The number and characteristics of patients served by organized family planning programs will be obtained from several sources. Over 75% of this data will be obtained from the information present in automated systems as it has been in the past. The remaining data also currently exists and will be obtained from sources which have been utilized in the past, i.e., Planned Parenthood Federation of America and a small survey of other providers.

3. Women served by private physicians will be estimated from several major sets of information. NSFG Cycle III provides statistics that indicate where the woman obtained family planning services. The National Ambulatory Medical Care Survey sample of private physicians will be used in conjunction with NSFG data to estimate the number of low-income women served by private physicians in different geographic areas.

4. Sources of funding for family planning services provided by organized programs will be gathered from two sources. All State Health, Welfare, and Social Service Departments will be asked to provide existing data on expenditures for family planning services funded by the Maternal and Child Health block grant, the Social Services block grant, Medicaid, and State monies. The second source of information on funding

for family planning programs is the BCRR Table E which reports all sources of income and expenditures (including patient fees and contributions) for each Title X grantee.

Task: For the nation and each county, estimate the number of women 44 years of age or under who are at risk of unintended pregnancy and in need of organized family planning services.

	Subtask	Completion	Person-Months
A.	Review and refine formula for estimating number of women in need	April	.50
B.	Collect latest available data needed to compute estimates from formula	May	1.00
C.	Construct computer files of data needed to compute estimates	June	1.25
D.	Compute estimates of number of women in need from computer files	July	1.25
E.	Analyze estimates and write a report on methods and findings	August	1.50
		Total......................	5.50

Task: Number and Characteristics of Patients served by the Organized Family Planning Program.

Subtask	Completion	Person-Months
A. Prepare and mail out request to automated data systems and non-automated organizations.	February	1.75
B. Complete list of independent clinics and mail out request for information.	April	2.25
C. Finish data entry and data processing of information received.	August	5.25
D. Compute estimation and projection of incomplete cells.	September	1.50
E. Perform analysis of data.	October	1.50
F. Complete first draft of report.	November	2.00
G. Finalize written report	December	2.50
	Total.....................	19.75

Task: For the nation and each state, estimate the number of low-income and adolescent women who received family planning services from private physicians.

Subtask	Completion	Person-Months
A. Review and refine methods for estimating number of women served by private physicians	May	.50
B. Obtain latest available data needed for estimating women served by private physicians:	July	1.00
(1) National Survey of Family Growth		
(2) National Ambulatory Medical Care Survey		
(3) National Medical Care Utilization and Expenditure Survey		
C. Complete construction of computer data files specified above.	September	1.25
D. Compute estimates of women served by private physicians from computer files.	October	1.25
E. Analyze estimates and write a report on methods and findings	November	1.50
	Total....................	5.50

Task: **Estimate expenditures for medical and social family planning services under Maternal and Child Health block grant, Medicaid, Social Services, block grant, and State funds.**

Subtask	Completion	Person-Months
A. Contact all State agencies involved in family planning.	March	1.50
B. Complete entry and production of BCRR Table 8 (itemized revenues and expenditures by Title X grantees by State).	March	.25
C. Enter and process data submitted by States; Incorporate BCRR data to file.	April	.75
D. Perform fiscal analysis of data.	June	1.25
E. Complete initial working draft of report and perform additional analysis as necessary.	July	1.25
F. Complete final draft of report.	August	1.00
	Total......................	6.00

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

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The Honorable Jeremiah Denton
United States Senate
Washington, D. C. 20510

Dear Senator Denton:

Thank you for your letter of April 13 enclosing questions for the written record on the subject of Title X. The responses to those questions are enclosed.

Sincerely,

Ed Brandt

Edward N. Brandt, Jr., M.D.
Assistant Secretary for Health

Enclosures

Question 1: Is there any reason why the Adolescent Family Life Program and the Title X program should not have independent administrators working under the direction of the DASPA?

Answer: Section 2009(b) of Title XX of the Public Health Service Act states that the officer designated by the Secretary of the Department of Health and Human Services to carry out the provisions of the Adolescent Family Life Act shall report directly to the Assistant Secretary for Health. However, it is consistent with the Title X statutue to have the director of the Title X program report directly to the Deputy Assistant Secretary for Population Affairs.

Question 2: How do you think that we can do a better job of ensuring that pregnant women hear more about all options available to them?

Answer: The Title X guidelines list the options which should be presented to pregnant women by Title X clinics. The family planning staff at the Regional Offices of the Public Health Service conducts site visits and program reviews of Title X projects to ensure that the guidelines are being followed. The regional family planning staff could devote special attention to the area of pregnancy counseling in site visits and program reviews. Also, they could identify whether there are further training needs of Title X personnel in this area and make arrangements for Title X training programs to provide instruction in the area of pregnancy counseling as needed.

Question 3: Mrs. Mecklenburg, do you have available a qualitative assessment of how Adolescent Family Life grantees have made a positive contribution to the reduction of adolescent pregnancy? Have you been able to apply these assessment criteria to family planning clinics serving teenagers?

Answer: Model demonstration projects awarded under the Adolescent Family Life Act are multi-year programs. It requires three to five years for a program to become established, obtain several years of client and program data, and complete a final evaluation. Since funds for the AFL projects were first awarded late in FY 1982, none of the projects have been in operation more than 18 months and none have completed final evaluations. Very preliminary findings obtained from the grantees are encouraging and suggest that the AFL projects will make positive contributions toward reducing adolescent pregnancy and ameliorating the frequently negative consequences associated with teenage parenting. When the final evaluations have been completed, the data from AFL projects will be assessed to determine if the services and assessment criteria would be useful in a number of Federal programs, including Title X, that serve adolescents.

Question 4: Could you describe in more detail, Mrs. Mecklenburg, the plans for the $5 million set-aside for projects of national priority? I'm especially interested in the areas of family involvement, natural family planning and infertility. Are these plans based upon what has happened over the last three years of the Title X program?

Answer: Based upon our experiences over the past three years, as well as those of the grantees, several areas were identified which warranted further encouragement and support. Therefore, each region was allocated $500,000 for National Priority Projects in five areas:

- Infertility Services
- Natural Family Planning
- Family Involvement
- Male Involvement

Existing Title X grantees have been informed about the availability of those funds and encouraged to apply. Interested grantees have submitted concept papers to the Regional Offices for review which include a statement of local need for additional activity in a National Priority area, a description of proposed activities, the number of clients to be served, a budget, and an evaluation plan. We expect that the National Priorities projects will be funded by July 1 for a minimum of three years.

National Priority projects are not a new phenomenom in the Title X program. In several previous years, funds were allocated for special initiatives or priorities. Historically, these funds have been distributed both on an equal basis among the ten regions and on a proportionate basis according to selected criteria. This year, as in the past, priority projects are for Title X services which have not been adequately addressed and require priority attention. Regions are working with Title X grantees to develop projects in all of these areas.

Question 5: What are you learning about under-served low income populations? How do you plan to target resources to those women most in need?

Answer: Data obtained from the Bureau's Common Reporting Requirements for FY 1983 to show that 84 percent of clients served are low income women. The Office of Family Planning is currently funding several Service Delivery Improvement Research Grants that are examining the family planning needs of low income women. One study is interviewing low income women concerning their satisfaction with family planning services obtained from clinics or private physicians. Another project is surveying low income women and will develop a model that will explain their choices of family planning providers. The results from these and other projects will help Title X clinics identify any changes that are needed to improve the delivery of family planning services to low income women.

To target resources to those women most in need, we will continue to emphasize services to low income women in our allocation formula which distributes money to the regions for Title X services.

Question 6:	I am very interested in the publications review project concerning those materials for teenagers. Can you describe to me any of the materials which have been reviewed and "have been pulled from the shelf"?
Answer	The Department has contracted to identify, acquire, assemble, organize, and assess copies of materials on adolescent sexuality under Federal sponsorship for the past 10 years. The contractor is now in the process of obtaining, organizing and cataloguing those materials as well as preparing an evaluation of the production quality of the materials, their completeness in terms of topical and audience coverage, and on the utility of this information. This process is still under way so we do not have the results of this review. When it is completed, it will serve as a basis for determining the usefulness of these materials.

Question 7: How can we help through amending current Title X legislation to forward the goals of the Department to have "100% of family planning programs with an established routine for providing an initial infertility assesment"?

Answer: The Title X legislation including the relevant Report language, has stressed the importance of family planning clinics routinely providing initial infertility assessments. This Administration has responded by setting aside $5 million for projects of national priority, including infertility services, as well as reminding the regions and local grantees of the necessity of providing these services.

Question 8: Does the DASPA have any remaining plans to effect cost savings based upon the 1981 GAO report, or other cost-benefit studies done on the Title X program?

Answer: The major thrust of the GAO report was that clinics could save money by reducing the number of return visits, cutting out routinely provided medical tests, (syphillis, gonorrhea, semi-annual pelvic) that do not appear necessary for all clients, tailoring educational counseling to the needs of the patient, and by consistently applying their sliding fee scales.

New Title X program guidelines were issued in July 1981 which:

-- changed medical revisit plans to agree with the American College of Obstetrics and Gynecologists Standards and Recommendations;

-- made gonorrhea screening a local decision;

-- required routine anemia screening only during initial medical examinations and required a request for waiver if the project director determines routine screening is not warranted; and,

- provided more flexibility to allow clinics to tailor educational programs to the client population served;

- included appropriate guidance for venereal disease.

The regulations contained in 42 CFR 59, Subpart A, Fee Scales and Collections, were included in the July 1981 new family planning guidelines. The regional offices were instructed to implement the mandatory program policy on patient fees.

The Regional Offices continue to encourage grantees to institute cost saving measures and we are anticipating the development of further cost savings measures as soon as the initial results from our most recent Service Delivery Improvement Research Grants and our Patient Flow Analysis are available.

Question 9: Mrs. Mecklenburg, the DASPA has been criticized by its detractors in the family planning industry for late reports, for example, the 5 year plan was late, wasn't it?

Answer: As part of the Department's effort to consolidate reports to Congress, last year the Public Health Service incorporated seven congressional reports, including the Family Planning Report, into a single report, "The Administration of the Public Health Service." Since this was the first effort to consolidate these reports, a lengthy review process was necessary which resulted in late submission of this report.

This year's family planning report is in the consolidated report which is expected to be sent to the Congress at the end of May. No delay will occur because of the family planning portion.

Senator **Denton**. Thank you, Dr. Brandt. I do not know how to estimate the chances of getting the block grant approach through this committee, but in view of the statements by Senator Helms regarding his leading a fight on the floor, I would be less certain. But from previous experience, although we did get certain votes through on this committee, I am not sure, in view of the traditional opposition to the block grant approach for anything and, perhaps, especially for this on this committee, I am not sanguine about the chances.

But I would like to welcome a gentleman with whom I serve, a man whom I respect, play tennis with, and admire very much, Senator Don Nickles from Oklahoma, who heads up, with a great record of accomplishment, the Labor Subcommittee. He is also a member of this subcommittee.

Welcome, Senator Nickles.

Senator **Nickles**. Thank you, Mr. Chairman.

I would just congratulate you for holding this hearing, and also Dr. Brandt, for his comments. I apologize for not being able to catch all of them.

I think it goes without saying that there are a lot of us who have concerns in this area, and we are appreciative of some of the remarks you made concerning block grants, et cetera. Hopefully, Congress will be a little more cooperative than we have been in the past.

Mr. Chairman, I do not have any opening comments. I want to participate in the hearing and find out where we are and what is happening. I have a schedule of funding amounts. We are looking in 1984 for title X. What is the funding level?

Dr. **Brandt**. One hundred and forty million dollars, total. Of that about $133 million will be for family planning services. Other funds will be used for training programs, for research, and so forth.

Senator **Nickles**. How much is in the budget for 1985?

Dr. **Brandt**. Well, in 1985 in the President's budget, we have put it into the primary care block grant. That included the full $140 million from this year, combined with the other elements of the primary care block, which include community health centers, migrant health centers, and black lung clinics, to make up the total figure.

Senator **Nickles**. Of that $133 million, are some of those funds distributed to various organizations?

Dr. **Brandt**. Yes. All of the funds are distributed to those people who operate the clinics, and there are roughly 4,500 family clinics now funded by those dollars across the United States.

Senator **Nickles**. The $133 million goes to how many clinics?

Dr. **Brandt**. Approximately, 4,500. I can get you the absolute, exact number. In 33 of the States, the full grant award is made to the State health department, and then the State health department—the concept behind that, which is something that we have accomplished in the last 3 years, was to permit there to be statewide planning, to permit the best kind of distribution of the funding to meet the needs of the people. So the State health department then turns around and either operates the clinics themselves or funds other organizations to operate family planning clinics.

Senator **Nickles**. Do most of those family planning clinics also provide abortions?

Dr. **Brandt**. The vast majority do not. The most recent data that we have, which admittedly is 2 or 3 years old, was that only 74—none of the clinics offer abortions directly—but that 74 of the organizations provide abortions in close proximity, that is, on the same physical site, although not the same facilities as the family planning clinic per se.

Senator **Nickles**. Could you give me a list of those organizations and how much money they have received?

Dr. **Brandt**. Yes, sir, we will.

Senator **Nickles**. How much money are we talking about in rough figures?

Dr. **Brandt**. I do not know, unless Mrs. Mecklenburg knows.

Mrs. **Mecklenburg**. I do not know, Senator.

Dr. **Brandt**. We will have to provide that for the record, Senator.

Senator **Nickles**. When you talk about the various organizations, is Planned Parenthood one grantee or does Planned Parenthood have individual grantees in each State, such as a District of Columbia family planning organization that is an affiliate?

Dr. **Brandt**. We would consider it a separate organization, although it may have some national—may belong to a national activity. The grant funds would be awarded to the local organization that operates the clinic, whatever legal structure they might have.

Planned Parenthood is certainly one of the larger—if you add it up across the country, Planned Parenthood is certainly one of the largest grantees.

Senator **Nickles**. Can you tell me how much money they receive?

Mrs. **Mecklenburg**. The Planned Parenthood affiliates that are affiliated with the national organization, we estimate receive about 21 percent of the funds, about $27 to $28 million.

I think, Senator, you would also need to know the way the system works as far as funding the grantees and the service providers.

The national office has an allocation formula where we divide up the money to the region, based on the women in need of services 150 percent poverty and below, the number of women served at that level, and some stability factor.

Then, the regional offices are the ones that do the review of the grant applications, the awarding of the grants, and the monitoring of the grants, so that that is decentralized and occurs in the 10 regions throughout the country. So that they have the primary responsibility of selecting and monitoring the grantees within their region.

Senator **Nickles**. Are the prohibitions that are currently in law against the funding of abortions, or against the funds being used for political purposes, adequate in your opinion?

Dr. **Brandt**. Well, certainly, the GAO report, I think, and our own Inspector General, who conducted some 30 audits, found no gross abuse—actually, found no abuse—with respect to either abortion or lobbying. The administration, as you know, across the entire Federal Government, has developed proposed rules concerning lobbying. And at the moment, we believe that the grantees are observing the prohibition against abortion.

Senator **Nickles**. Dr. Brandt, have you seen the full-page ads taken out by some of these organizations like Planned Parenthood?

Dr. **Brandt**. Yes.

Senator **Nickles**. You do not think that because they are receiving this $27 or $28 million that this might allow them to use other funds for lobbying purposes or for abortion purposes?

Dr. **Brandt**. Well, I suspect that that is possible, Senator, but I would only point out to you that experienced auditors who have examined this have not come to that conclusion. But I certainly am aware of the ads, and I am certainly aware that a fair amount of money is spent.

However, I think because an organization receives Federal funds, one cannot determine everything, I guess, that that organization does any more than we can for State health departments.

Senator **Denton**. Will the Senator yield? I know you have a shortage of time.

Senator **Nickles**. Certainly; I will be happy to yield.

Senator **Denton**. I am pursuing your question here, and I would like to ask Dr. Brandt something that I think will cast light on that about which you are curious, and that is, whether or not the grantees, one way or another, are promoting, sponsoring, making easier than otherwise, abortions—is that the kind of thing you are getting at?

Senator **Nickles**. And the fact that there are taxpayers' dollars involved.

Senator **Denton**. Right; one thing you are going to find a little tough—certain grantees receive private money; certain grantees receive Federal money, and then certain grantees erect signs, which I could not pay for during my campaign, 15, or 16, or 17, and the biggest city in my State placing me, or somebody who looks a lot like me, between a married couple in bed, and so on. I cannot prove where they got that money, but certainly, they could have used it on some help to the poor, rather than lobby.

Here it is. Senator Helms claims that it is he. I do not know whether it is he or I, or whom. But I do not know how much money of that came out of taxpayers, pockets, and I cannot prove it, nor can anyone else.

Dr. Brandt, I am going to read the list of activities related to abortions, and ask you to tell me whether or not each one of them is allowable under the title X program. If the activity is allowable, please say yes, and if it is not allowable, please say no. And I would ask Senator Nickles to hear these.

First, for the activity to provide information about abortion services.

Mrs. **Mecklenburg**. No.

Senator **Denton**. To provide the name, address, and telephone number of abortion providers.

Dr. **Brandt**. Yes; that is allowable.

Senator **Denton**. To collect statistical data and information regarding abortion.

Dr. **Brandt**. Yes.

Senator **Denton**. To inspect facilities to determine their suitability to provide abortion services.

Dr. **Brandt**. Yes; that would be allowable.

Senator **Denton**. To pay dues to organizations that advocate the availability of abortion services.

Dr. **Brandt**. Yes.

Senator **Denton**. To provide transportation to an abortion center or providers.

Dr. **Brandt**. No; that is not allowable.

Senator **Denton**. That is correct.

To provide counseling that encourages a person to obtain an abortion.

Dr. **Brandt**. That is not allowable.

Senator **Denton**. To provide pro-abortion speakers to debate the issues in public forums.

Dr. **Brandt**. Well, they cannot use Federal funds for that purpose.

Senator **Denton**. To advocate the need and suitability of abortion services in the community.

Dr. **Brandt**. Again, they could not do that using Title X funds.

Senator **Denton**. Do you know, in making that distinction repeatedly, whether the grantees, through one set of funding or another, are doing those things?

Dr. **Brandt**. Oh, yes, sir, I think there are some of our grantees that at least are doing the second; I am not aware of the other——

Senator **Nickles**. At least are doing what?

Dr. **Brandt**. At least are providing speakers.

Senator **Nickles**. Providing speakers?

Senator **Denton**. Proabortion speakers. And we have lists and literature and everything else to back up the questions we are asking.

To produce or show movies that tend to encourage or promote a favorable attitude toward abortion.

Dr. **Brandt**. They are not permitted to do that, no.

Senator **Denton**. To provide abortion as a suitable backup method of family planning.

Dr. **Brandt**. No.

Senator **Denton**. To make specific appointments or referrals for an abortion, unless medical conditions warrant.

Dr. **Brandt**. Not unless medical conditions warrant, no.

Senator **Denton**. To bring legal action to liberalize abortion-related statutes.

Dr. **Brandt**. Again, they cannot do that using Federal funding.

Senator **Denton**. But without knowing where their funds are coming from, are you aware that this is being done by many grantees?

Dr. **Brandt**. Yes, sir.

Senator **Denton**. Pressure local governing bodies to change restrictive abortion policies.

Dr. **Brandt**. There are grantees that do that, again, not using Federal funds.

Senator **Denton**. The first question we asked, which Mrs. Mecklenburg answered, I maintain was answered incorrectly. The question was, Can the activity provide information about abortion services, and she said, "No," and to my knowledge, the answer to that question is "Yes."

Dr. **Brandt**. Well, they cannot do it in the conduct of the family planning clinic services that they are providing with Federal funds. There is nothing that would prohibit a grantee providing under other conditions and in other settings that kind of information.

Senator **Denton**. Yes; the question is, which money is it coming from when they lobby this way and that way, or advise for abortion.

According to the GAO, the first five of the activities I mentioned are allowable under title X programs, and the remainder are not allowable. However, these policy positions are based only on ad hoc internal HHS general counsel opinions. They have not been formalized and incorporated in the program regulations and/or guidelines. The GAO report recommended that the Secretary establish as explicit guidances as possible on the activities that are and are not allowed. The Department's response to the GAO report was that the Secretary would direct the Assistant Secretary for Health to include in title X program guidelines an explanation of the Department's position on implementation of section 1008. Until the Department has done that, I consider it inappropriate for the administration to contend that current grantees know and do honor section 1008 prohibition. And I heard that remark made.

Do you have any intention of formulating new guidelines and regulations?

Dr. **Brandt**. Well, we are, in fact, and have been, looking at this issue, attempting to develop the guidelines in a realistic and workable way. In the interim, a number of other steps have been taken, and Mrs. Mecklenburg can give you some of the steps that we are taking.

Senator **Denton**. The GAO report was issued in September 1982. When do we plan to come out with it, Mrs. Mecklenburg?

Mrs. **Mecklenburg**. Well, you may not be aware, Senator, but I would like to let you know that we have been working on it, and there have been a number of steps that have been taken by the Department in examining this issue and working with it. There was a preliminary draft that was circulated, prepared by the Bureau before the program was transferred, which had not been reviewed by general counsel or anyone else in the Department, and then became public. And there were such a number of reactions from people on all sides of the issue, that this would do nothing, or this would cripple the family planning program, that it was clear that this was an extremely complicated issue.

We are continuing to work with it and to see if we can come out with something that will be reasonable to be implemented in the family planning program and allow for exactly what the law and the opinions do require.

I think that one of the issues that repeatedly comes up is the issue of funding an entity that is involved in providing abortion or promoting abortion. And the question is whether Federal funds can be given to that entity at all; what is the amount of overlap and comingling that happens. Is there a point at which this is so enmeshed that you cannot keep it really pulled apart? And that is a question that GAO has suggested needs more guidance from the Congress.

Senator DENTON. If I may politely inquire. The statement, in spite of the complexities which you appropriately mention and the complexities and difficulties in sorting out, which I totally concur in, how can the statement, then, be flatly made that there is no problem, that there is no violation?

Mrs. MECKLENBURG. I think, Senator, what Dr. Brandt was responding with is the information from the GAO and the IG audits. Since they have found——

Senator DENTON. I believe, Mrs. Mecklenburg, and you can correct me if I am wrong, that they referred to direct funding for abortions from the clinics—not to this question which we are examining now, which is many-faceted, regarding whether or not there is counseling for, speakers for, et cetera.

Mrs. MECKLENBURG. My recollection of the various audits was that they looked into a number of different kinds of practices, not just direct funding of abortion, but what kinds of practices were incurred, and what were in the service centers.

Now, I believe they looked at a number of different issues, Senator.

Senator DENTON. OK. Well, I would receive a different impression from the book, report, by the Comptroller General of the United States, the title of which was "Restrictions on Abortion and Lobbying Activities in Family Planning Programs Need Clarification." That, in their view, was the answer regarding the situation. They say, "Some counseling and referral practices may not be appropriate." That was a subhead, on page 15. Another was, on page 14, "HHS's program regulations and guidelines do not reflect its policy on abortion restrictions." So, one, we are hoping that that eventually does come out; two, I cannot help but express reservations about an unqualified statement that everything is in the clear that way; that some clinics; practices may go beyond mere referral, which is another subhead in the report which I am citing here, and I would ask that at least the excerpts which I mentioned be included in the record, the report by the Comptroller of the United States, "Restrictions on Abortion and Lobbying Activities in Family Planning Programs Need Clarification."

[The excerpts referred to follows:]

(EXCERPT FROM REPORT BY THE COMPTROLLER GENERAL OF THE UNITED STATES--RESTRICTIONS ON ABORTION AND LOBBYING ACTIVITIES IN FAMILY PLANNING PROGRAMS NEED CLARIFICATION--GAO/HRD-82-106--SEPTEMBER 24, 1982)

HHS' PROGRAM REGULATIONS AND GUIDELINES DO NOT REFLECT ITS POLICY ON ABORTION RESTRICTIONS

The position that section 1008 not only prohibits abortion as a method of family planning, but also prohibits activities which promote or encourage a favorable attitude toward abortion as part of the title X program has not been incorporated into HHS' regulations or guidelines. In contrast, HHS relies on its program regulations 1/ and guidelines to provide guidance on other major policies to title X recipients. In effect, HHS' regulations that spell out overall policy and implement provisions of the law and corresponding program guidelines that elaborate on the law and regulations in operational terms do not contain the specific policy guidance concerning section 1008 needed by title X recipients.

We could not determine from discussions with HHS' officials the reaons why HHS elected to exclude from its regulations and guidelines its position on the scope of prohibitions in section 1008. HHS' regulations (dated June 1980) and its prior regulations simply state that title X projects shall not "* * * provide abortion as a method of family planning." The policy that section 1008 also prohibits activities which promote, encourage, or advocate abortion are not mentioned in HHS' regulations. Also, the HHS program guidelines for family planning services refer to the title X program regulations with no elaboration on the meaning of section 1008.

HHS, however, has periodically issued memorandums to its regional program administrators containing Office of General Counsel interpretations of section 1008. Five of six regions we visited had transmitted this information to grantees, but only 3 of the 10 grantees passed it on to their delegate agencies and clinics. Of 14 clinics visited, only 6 had received HHS' legal interpretations of section 1008.

While this process made HHS' policy available to some title X clinics, the policy was nevertheless not included in the regulations and guidelines that grantees are required to follow as a condition of their grants. For example, the title X grantee in Los Angeles, according to its executive director, has received no written guidance from HHS on interpreting section 1008. This grantee, one of the largest nationally, had 26 delegate agencies that operated 94 clinics.

1/42 C.F.R. Part 59.

SOME COUNSELING AND REFERRAL PRACTICES MAY NOT BE APPROPRIATE

Under the HHS program guidelines, pregnant women should be offered information and counseling regarding their pregnancy. The guidelines state that individuals requesting information on options for managing an unintended pregnancy are to be given nondirective counseling 1/ on the options available and referred upon request, including being referred to abortion providers. At the clinics reviewed, the number of pregnant clients coming to clinics for their first visit represented between 5 and 69 percent of the clientele.

1/Nondirective counseling is the provision of information on all available options without promoting, advocating, or encouraging one option over another.

At 10 of the 14 clinics visited, counseling was available through the title X-supported programs. At the four other clinics, one did not provide any counseling and the other three provided counseling, but not as part of their title X programs. Officials at all clinics which provided counseling indicated that they provided only nondirective counseling in accordance with HHS guidelines. Referral practices varied from clinic to clinic, and some clinics did not comply with HHS' policy position. We did not find any evidence, however, that pregnant women were advised to have abortions. 1/

Counseling practices

Typically, counseling of pregnant women occurred after clients received tests that confirmed their pregnancy. When the pregnancy was desired, clients were generally advised to seek prenatal care and given referrals if needed. If a woman indicated the pregnancy was unintended or not wanted, counseling was generally provided. Officials at the 13 clinics offering counseling said that nondirective counseling was available on the following options:

--Prenatal care and delivery.

--Infant care, foster care, or adoption.

--Pregnancy termination.

The pregnancy counseling provided by clinics varied as shown below:

--Seven clinics counseled clients, but only on the option they decided to pursue.

--Four clinics counseled clients on all options when the client expressed that the pregnancy was unintended or she was unsure of what to do.

--Two clinics counseled all pregnant women on all options available to them.

One of the 13 clinics offered followup counseling to clients referred for abortions, although officials at all clinics said postabortion counseling was available if requested by the clients.

According to HHS' headquarters officials, all options do not have to be discussed, but they believe it is "professionally incumbent" upon the counselors to discuss other options with women

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1/None of the clinics reviewed provided or referred any client for menstrual extraction procedures.

who say they are only interested in abortions. When a woman is interested in continuing her pregnancy, HHS' officials said that abortion should not be discussed.

Eleven of the clinics required their counseling staffs to take training and/or participate in an appropriate orientation course covering problem pregnancy counseling and referral policies. The academic background of the staff providing counseling varied. Registered nurses and nurse practitioners often provided the counseling to pregnant clients. At some clinics, counselors had advance degrees in the fields of psychology or social work, and at other clinics the counselors had no formal credentials or degrees in areas related to counseling. Typically, the counselors had not received formal training in counseling pregnant women, but at most clinics counselors had some formal or in-service training in related areas, such as crisis counseling.

We were advised by clinic officials that the topic of abortion and counseling often came up spontaneously during in-service training and other courses. Clinic officials said they always emphasized a nondirective and unbiased approach to counseling pregnant women. Interviews with several counselors showed that they were aware of restrictions against encouraging or advising clients to have abortions.

Questionable counseling practices

Seven clinics did not provide counseling on all options available to pregnant women. At one clinic, women were required to complete paperwork before their pregnancy tests and preselect how they intended to deal with their pregnancy. If they chose to continue the pregnancy, they were counseled on that option. If they checked abortion, they were counseled only on that choice. Six other clinics, which did not require prepregnancy test decisions, did not routinely counsel women on other alternatives if they had decided on abortion. Based on the HHS guidelines which recommend that all options be discussed with clients deciding on abortion and HHS' officials views that it is "professionally incumbent" to discuss all options, these practices are questionable.

Referral process

When clients are counseled and choose to terminate their pregnancies, referrals may be made to abortion providers. The extent to which clinic personnel can assist clients in making abortion arrangements is limited, according to HHS' interpretation of section 1008. HHS' referral policy, however, is not clearly stated in the program regulations or guidelines and certain abortion referral practices by title X recipients raise questions as to whether they go beyond the "mere referral" HHS maintains is permitted under the law.

Title X regulations require that each project provide clients with medical services related to family planning and make referrals to other medical facilities when medically indicated. Therefore, if continuing a pregnancy would endanger the mother's life, a referral to a provider who might recommend or provide an abortion would be medically indicated. However, the regulations are silent on the referral process for abortions in other instances.

Since 1971, HHS has relied on legal opinions that applied the concept of "mere referral" to the restriction imposed by section 1008. Under this concept, title X program funds may not be used to make an appointment for a woman, to provide transportation, or to take other affirmative action to secure an abortion.

The title X program guidelines, issued in 1981, provided that women needing services, which are beyond the ability of the clinic to provide, should be referred to other providers for care. This provision, however, as it relates to abortion referrals, does not reflect the "mere referral" concept traditionally held by HHS. Although HHS' officials advised us that the "mere referral" concept has been agency policy on abortion referral, they did not explain why this policy had not been included in program regulations or guidelines.

We reviewed several clients' charts to determine, among other things, the referral outcomes at the clinics visited. The results of our review cannot be projected, but provide a limited perspective on referral outcomes at these particular clinics. The results are shown on the next page.

Some clinic practices may go beyond "mere referral"

Referral practices varied, but most clinics provided some type of information on the sources of abortion services to clients desiring to terminate pregnancies. By applying HHS' policy, we identified the following practices that could be construed to go beyond the "mere referral" policy:

- --Four clinics provided clients brochures prepared by abortion clinics. Some of the HHS regional staff were not sure this practice was acceptable, while others felt it was reasonable and within the spirit of HHS' policy.

- --At two clinics, clients seeking abortions were allowed to use the telephone to make appointments for abortions. HHS' officials were not sure this practice was within the spirit of the HHS policy because it went beyond the concept of providing information with no further affirmative action.

Summary of Referrals Made by Title X Recipients

Clinic type	Estimated pregnant women (note a)	Records reviewed and age of clients: 19 and under	Records reviewed and age of clients: 20 and over	Records reviewed and age of clients: Total	Type referrals made: Pre-natal	Type referrals made: Adop-tion	Type referrals made: Abor-tion- (note b)	Type referrals made: Mul-tiple (note b)	Type referrals made: None	Type referrals made: Not in-dicated
Public:										
City/County	14	8	6	14	8	-	-	-	-	6
County	25	10	3	13	4	2	2	-	-	5
County	348	4	46	50	48	-	1	-	-	1
County	899	18	32	50	27	-	10	1	3	9
Other nonprofit:										
Planned Parenthood	402	11	39	50	15	-	15	12	1	7
Planned Parenthood	25	11	14	25	1	-	1	1	-	22
Planned Parenthood	592	22	28	50	13	1	5	-	-	31
Planned Parenthood	50	20	30	50	14	-	26	-	-	10
Planned Parenthood	551	24	26	50	24	-	21	2	-	3
Planned Parenthood	(c)	10	12	22	1	-	19	1	1	-
University	220	22	28	50	25	1	-	-	-	24
University	(d)	-	-	-	-	-	-	-	-	-
University	(e)	-	-	-	-	-	-	-	-	-
Private	53	9	41	50	42	-	-	1	3	4
Total	3,179	f/169	305	474	222	4	100	18	8	122

a/Information concerning marital status, race, and previous abortion history was not maintained or was incomplete.

b/In some instances women received referral for both abortions and prenatal care.

c/No estimate available.

d/Clinic did not offer pregnancy counseling.

e/No client files reviewed--clinic did not have current contract with title X grantee.

f/In total 116 clients were 18 years old or younger.

--At one clinic, appointments for abortions were made for clients who did not speak English. (The HHS Inspector General identified two other instances of counselors making abortion appointments for clients.)

--At one clinic, the title X recipient provided women loans for abortions from nonprogram funds; however, administrative costs associated with the referral and loans were charged to title X program costs. (A similar observation was noted by HHS' Inspector General.)

The Office of the Inspector General also identified that several title X clinics in Indiana provided and witnessed the signing of consent forms required by an abortion clinic. This practice is prohibited by section 1008, according to HHS, since it could be considered promoting abortion. The title X grantee indicated that the consent form was completed only after women had decided to have an abortion and that the practice simply facilitated the abortion decision and did not encourage or promote abortion. HHS regional officials ordered the practice stopped as part of the title X program, and the recipient told us it had passed the instructions to its delegates.

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Senator **Denton**. If I may pursue just one question further, regarding the block grant and the advisability and feasibility of the States delivering the services, there was such a study made in your department—is that right, Dr. Brandt?

Dr. **Brandt**. That is correct; yes.

Senator **Denton**. I do not know if this is true or not—I am only reading it in the NFPRHA News—but they carried two stories about this, and one of them says that the HHS report was deemed by the general counsel of HHS to be effectively invalid, in that it appeared to argue the case for State administration of title X, rather than simply presenting the facts found upon study.

I have read the note which is part of the leak, and I am not convinced one way or another, but it does make me wonder if there are leaks within HHS which are at odds with one another about point of view on this subject, and whether or not we are going to receive from HHS an objective opinion based upon law and fact, or are we going to receive power politics, influence within the Department on people's jobs, and subjectivity rather than objectivity.

Dr. **Brandt**. The report on States' ability to administer the program is currently in the process of undergoing review by departmental offices, including the Office of General Counsel. As often happens, I have not seen the memorandum, which is already printed in outside newspapers—but that is not terribly unusual——

Senator **Denton**. Well, things are proceeding with glacier-like speed, because within 18 months of the passage of the Omnibus Reconciliation Act, we were supposed to have this thing, and if the general counsel did not like it, it looks like it could have been fixed up in the meantime, such that it could be passed on in accordance with the mandate of the Congress.

Dr. **Brandt**. Well, the latest word that I have is that the general counsel has cleared that report, and it is now going through the usual review process within the Department to be released. And the general counsel supposedly has said it is OK, I mean, has no legal problem. I will go back and find out. Maybe NFPRHA writers know more about what is going on that I do, but certainly, we have it approved by them. So you will——

Senator **Denton**. Well, I hope to see that. Could you give us an estimate on the date at which this cleared report will get down to us?

Dr. **Brandt**. I would hope you would get it within the next 2 or 3 months. It has been cleared by me and gone on to the rest of the Department for its clearance, and I must say that I do not know the exact status of it in that process.

Senator **Denton**. Well, that is after we are supposed to have decided on the block grants, after we are supposed to have reauthorized this bill, after we adjourn, I believe. So it is a very convenient or inconvenient time, depending on your point of view, to receive something that ought to have been received a couple of years ago.

Dr. **Brandt**. My own view is that it is a very good report, and I would hope that we can speed it along. And I can assure you that when I get back, I will try to do that.

Senator **Denton**. Well, could we get any preliminary form of it? If NFPRHA printed it some time ago, January 6 of this year, would you grace us with some information about the content of the report?

Dr. BRANDT. Obviously, I will have to discuss that with the Secretary, since the report will be coming up over her signature, and see what we can do.

Senator DENTON. I am going to go back to Senator Nickles, because he does have limited time.

Senator NICKLES. Thank you, Mr. Chairman.

I have a couple of questions. The language says, "None of the funds appropriated under this title shall be used in a program where abortion is a method of family planning." I believe you responded that 74 clinics had abortion on the same site; is that correct?

Dr. BRANDT. Yes; most of these are hospitals, Senator, where they will have a clinic for family planning in one place, but within the same building, also offer abortions, so that they are simply on the same physical site, not within the same facility, delivering the family planning services.

Senator NICKLES. Do you have some that are not hospitals, but instead house a family planning clinic in one room or building, with an abortion clinic upstairs or across the hall?

Mrs. MECKLENBURG. Yes.

Senator NICKLES. Would you consider initiating a regulation to prohibit any Federal funds from going to clinics which perform abortions on the premises?

Mrs. MECKLENBURG. That depends on whether there is a basis in the law, and interpretations, to be able to do that—because we are now getting into the question of the definition of the project, the clinic, the entity, in other words, who is it that is receiving Federal funds? Is it the family planning clinic and its operation and its confines, or is it the entire hospital or the rest of the clinic, where other things are going on, that are funded through other sources? And one of the things that has been difficult over the years to know, evidently, is what Congress' intent was in that regard. And the GAO pointed out that, in addition to us offering some further clarification in the Department, that on that question, they felt that Congress might want to offer further clarification about what they mean as far as a program funding a particular entity or program, and how far removed from abortion does it have to be. If the funds are not going into it directly from title X, and it is funded through other sources, then how far removed does that other kind of program have to be, Senator. That is one of the difficulties in arriving at this in that way.

Senator NICKLES. I think that if one is a family planning clinic and one is an abortion clinic, and they have like directors, responsibilities, employees, overhead, administration, et cetera, then certainly, you have a Federal subsidy——

Mrs. MECKLENBURG. Well, that would certainly provide that kind of basis, yes, I would agree with you.

Senator NICKLES. Well, I am concerned when you tell me that there are 74 cases in which abortion clinics actually exist on the same premises as family planning clinics. I hope that you will consider trying to tighten that up, because I think the language is really quite clear. "None of the funds appropriated under this title shall be used where a program for abortion is a method of family planning." I think that is very clear.

Let me ask another question. I am assuming that there is an Interagency Family Planning Council in Washington, DC. Do you have a list of whether or not Planned Parenthood of Metro Washington, DC has received a grant lately?

Mrs. MECKLENBURG. They used to be the grantee, but the Council of Governments is now the grantee for Washington, DC, the District of Columbia. So they are no longer the grantee, I am advised.

Senator NICKLES. Do they still get Federal funds?

Mrs. MECKLENBURG. Well, to the extent that funds are available for low-income people through other sources, other than title X; most programs get some reimbursement for low-income people through a variety of sources in the Federal Government.

Senator NICKLES. In February of 1982——

Mrs. MECKLENBURG. Excuse me, Senator. Because they are not the grantee does not mean they would not necessarily be getting any grant money. Let me explain to you. We have a grantee, and then the grantee has delegate agencies that also provide services. The region administers that program again, and I would have to find out for you—I know they are not the grantee—I would have to find out specifically if they were a delegate agency receiving, in a secondary way, any funds from title X. But I could find that out through the regional office.

Senator NICKLES. Would you do me a favor and find out for the committee whether there were any Federal funds involved in this event that was put on? I suppose that it was sponsored by the Men's Center, Planned Parenthood of Washington, DC, on February 14, 1982, National Condom Week?

Dr. BRANDT. There was some Federal funding involved in that. That was repaid, however.

Senator NICKLES. What amount of Federal funds were involved in that event?

Dr. BRANDT. It was $500 or $600—not very much. And that was repaid.

Senator NICKLES. That was repaid. When was it repaid?

Dr. BRANDT. It was repaid shortly after we asked them for it, which was not long after the event was held and we became aware of it.

Senator NICKLES. Are there similar types of events happening? I might have missed this year's week.

Dr. BRANDT. If those events of that general nature are paid for from Federal funds, we will, of course, usually learn about that through regular audits, et cetera, and we will ask them to pay the money back. But I am not aware—I have to tell you that I had never heard of National Condom Week until that particular event was brought to my attention, and we made moves to get the money back. And whether or not the event is being held this year or any other activity similarly, I am just not aware of.

Senator NICKLES. Are you satisfied that the regulations are strong enough to prohibit these organizations that are receiving Federal funds from lobbying?

Dr. BRANDT. The new regulations that have been drafted out of the Office of Management and Budget, I am assured by their counsel will be, yes, sir.

Senator NICKLES. Will be?

Dr. BRANDT. Yes, sir. They are not final regulations at the moment.

Senator NICKLES. But you do not believe that they are strong enough today.

Dr. BRANDT. I do not think they are strong enough today, no.

Senator NICKLES. I don't, either, and I am concerned. You will provide this committee with a list of what groups are receiving Federal funds and how much money they are receiving, is that correct?

Dr. BRANDT. Yes, sir.

Senator NICKLES. Correct me, but I think you mentioned Planned Parenthood affiliates were receiving, $27 to $28 million?

Dr. BRANDT. Yes.

Senator NICKLES. Is that on an annual basis?

Dr. BRANDT. Yes, sir. They receive about 21 percent of the appropriation and have for the past 2 or 3 years.

Senator NICKLES. Has that been going up or down?

Dr. BRANDT. It has been fairly steady, I think, as a matter of fact.

Senator NICKLES. Do you have any idea what percentage of their overhead or operating expenses are? I will ask them that question too.

Dr. BRANDT. I do not know, no, sir.

Senator NICKLES. I am very much concerned about the lobbying, and I would hope that the administration would work to see that the Federal taxpayers' dollars are not used to come up with ads that I think are misleading. They certainly should not be subsidizing ads to lobby Congress one way or the other on these issues.

Thank you, Mr. Chairman, for allowing me to ask a couple of questions.

Senator DENTON. Thank you, Senator Nickles. We appreciate very much your attendance here this morning.

Senator Hatch is unable to be with us today, tied up in other duties. However, he wants us to let it be known that he will continue to be active in the legislative process concerning the reauthorization of the title X program, and I will at this time submit a prepared statement for the record. He has submitted some questions for the record, and has asked me to raise one question at the hearing with Dr. Brandt, which I shall now do.

We are going to have to go vote. We have five bells and less than 6 minutes to get over there now. I am surprised we were not informed about the vote.

So, we will recess for 7 minutes.

[Short recess.]

Senator DENTON. Ladies and gentlemen, the hearing is reconvened.

Before I ask this long question of Senator Hatch's, I think I should ask one more in a continuum that has been developing with regard to the slowness of speed with which certain documents are made available. In all fairness, I should express my current curiosity as to whether the DASPA office has sufficient staff to efficiently deal with the responsibility that it now has, and has staff limitation played any part in the slowness with which some of these documents have been forthcoming or not? Can you tell me how many employees the office now has and approximately how many employees, in your opinion, it should have, Mrs. Mecklenburg—and I would also like Dr. Brandt to answer that question, but since she is on the spot with that job, I direct the question to her.

Mrs. Mecklenburg. In the Office of Population Affairs all together, we have 27 out of the 40 positions filled. I have excellent staff in the family planning area. I have people who have had a great deal of experience in a number of parts of the program. My associate who actually ran the family planning program when it was in the Bureau for 4 years, was the acting DASPA, and directed the Office of Population Affairs. I have a demographer and Ph.D. in the Office of Population Affairs, who is helpful in the family planning program as well as the adolescent family life program, who had prime responsibility for the National Survey of Family Growth, which is one of the main sorts of surveys where we get our reproductive health information. I have another sociologist Ph.D.; I have people who have been part of the original family planning years ago, the original Federal program; people in the regions, from regions, who have had family planning experience in the regions and who have had other kinds of experience dealing with the regional structure.

So I feel that I am well-staffed with people with the kinds of skills that are needed to run a quality program.

As far as lateness, Senator, I know that there are groups and individuals who have been complaining about the fact that things do not always get in at the time they would like to see them. We always regret that, too, but as you recognize, and we discussed earlier in this hearing, there is a long deliberative process that always has to be undertaken in a bureaucracy and much review that is necessary.

I would like to make two points—first of all, that this is the case; and second, each time this complaint has come up, we have looked at, very carefully, past practice and have aimed to try to get things in on time. And I think that we can clearly say that our time schedule compares very favorably with the past and the submission times of reports. There have always been problems. For instance, with the 5-year plan, Congress actually changed the date because it was always so late. When we submit the 5-year plan, even at our level, we have to coordinate things from other agencies like NIH and other parts of the agencies that have family planning responsibility. We cannot always control the time when their submissions come to us, and then we pass it forward. But I can tell you that we strive very hard to get the information to you and to do a quality job. We feel that those are both very, very important things to be concerned about.

Senator Denton. There was an administrative directive issued 3 years ago to require title X grantees to report quarterly on their family involvement activities, and we did get the encouragement of family involvement as part of the compromise that Congressman Waxman and I drafted in 1981.

Are you aware of that requirement, Mrs. Mecklenburg?

Mrs. MECKLENBURG. Yes, Senator. We have been working to encourage family participation in our clinics. You are undoubtedly aware of the money and the allocation formula, the $5 million for special national priorities in each region. One of those priorities, along with natural family planning, and infertility, male involvement, or special regional interest, is family involvement. We hope to have some very special kinds of model programs that will help grantees in the implementation of this part of the law.

In addition, in the testimony, you will find other kinds of activities that we have undertaken since the transfer of the program, to improve family involvement and to strengthen those practices in the regional offices and in the grantees' service delivery system.

Senator DENTON. That was 1981 in which we drafted that new requirement on which we had mutual agreement, that is, more family involvement. That lack of identity between Congressman Waxman and myself is perfectly clear. We disagree as to the manner and degree of family involvement, to some extent, which is not entirely defined between the two of us. In talking with NFPRHA the other day, I do not know to what degree I disagree with them regarding family involvement, because I do not think they have a unanimous opinion. I know that I would like to see the families involved, granting that communications between parents and children on sex is one of the most difficult types of communication in the world, I believe that once the child, say, a female, 13 years old, has received counseling, unheard by the parent, and from what I have seen, very frequently in disagreement with what the parent would pass on in terms of values, and then makes a decision to commit herself to sexual intercourse on a regular basis with a young man, that the parent deserves to know about that and also know about the fact that prescription drugs or devices have been issued. I do not hide that. That is the way I believe. I understand there are arguments to the contrary, and I have to honor what is law, but I want to be consistently honest about expressing my own opinion.

Other than the effort on parental notification regulation which was struck down by the courts on the basis of a lack of statutory intent, has the administration attempted to describe or define family involvement goals thus far for family planning grantees, and when do you think we can expect that you might do so, if you plan to do so?

Mrs. MECKLENBURG. We have at this point worked with the regional offices in order to give people some broad latitude in family involvement, and to encourage innovative activities. This is part of our strategy, realizing that it is sometimes difficult to involve families, recognizing that people on all sides of the issue would like to see more family involvement. We have attempted to try to see whether we could find some ways in which that involvement could be increased, to fund some successful models, and to encourage the replication of those models. So in addition, we have worked on preparing materials, screening the materials that the Government already has published, to see that it encourages postponement of sexual activity, that it encourages communication between parents and their children, and we have also sponsored the production of some Hispanic materials for these parents to help them communicate their values to their children. In addition, we have worked with the regions, as I think you will see detailed in the testimony, to see that every one of the grantees has a family involvement policy, has a plan for increasing family involvement, and actually has training of their boards, both the advisory board and the governing board, to inform them about ways they can increase their family activities and family involvement.

So I feel that we have done an excellent job since 1981 in the administration of encouraging and working toward greater involvement of families in the title X programs.

Senator DENTON. I just do not see that reflected in the field, because there is no definition of what is to be done in the field, except general statements about, "There will be," or "we are in favor of family involvement." This can take place in some high-level counseling committee, or it could take place with the individual's child, and no one knows right now, at least I do not, and I earnestly am seeking to find out where we are and where we are going with that.

Now, this is Senator Hatch's question, and after that, we will be introducing Dr. Pawlewski, and we have Senator Grassley here, whom I would like to welcome and thank for his interest in this field and to congratulate for his very considerable victory yesterday with the Older Americans Act, which required a tremendous amount of leadership on his part.

Welcome, Senator Grassley.

Senator GRASSLEY. Thank you very much; I want to say I was absent due to my attendance at the Judiciary Committee meeting. I know you are also on that committee, and you had to give priority because of your chairmanship here.

My purpose for stopping by for just a few minutes at this point is because I want to remind you and also the audience that a constituent of mine, Mr. Pawlewski, is here. He is commissioner of the Iowa State Department of Health, and has a broad background in various health services. He has been commissioner of our State since 1973, and I have had the pleasure of working with him both now, as a Senator, a Congressman, and before that, as a member of the Iowa Legislature.

I also want to thank you for the work that you are doing in this area, and hopefully, legislation will evolve.

I will probably have some questions I would like to submit in writing, and I want to thank you for letting me take time out of order to make these comments about my constituent.

Thank you.

Senator DENTON. Thank you, Senator Grassley, and I hope that I survive Chairman Thurmond's wrath at not being there.

Senator GRASSLEY. You did, and let me say we have adjourned now, and we have put off until 9 o'clock next Thursday consideration of McClure-Volkmer.

Senator DENTON. Thank you very much.

During Mrs. Heckler's nomination hearing before this committee on March 3 of last year, Senator Hatch asked the following question—and I will ask it for the record and give her response, and then there will be a question for you two.

He asked this question: "What is the current status of the conscience regulations which prohibit title X recipients from employment discrimination against medical personnel and staff who are antiabortion? Do you support these regulations?"

Secretary Heckler's response was: "As you know, a section enacted as part of the Health Programs Extension Act of 1973 and subsequent amendment, prohibits discrimination against medical personnel on the basis of their religious beliefs or moral convictions respecting abortion or sterilization procedures. This provision protects those who are opposed to such procedures, as well as those who favor them." She goes on: "I am very supportive of this statutory concern. In fact, as a Member of Congress, I introduced several bills on this subject. The issue of the lack of regulations implementing this statutory passage was raised several months ago. The decision was made to develop regulations, and staff are currently working on them."

Over a year has passed since that March 3, 1983, question. Can you describe where these regulations now stand?

That is Senator Hatch's question.

Dr. **Brandt**. The regulations have not yet been drafted, Senator. The regulations to implement the conscience clause, in the first place, I think we need to appreciate that in the past few years, the climate in this country has changed dramatically with respect to the appreciation of differing viewpoints on certain issues such as abortion. I think the only case that we are aware of that has filed for discrimination was a physician who favored abortion and was denied hospital privileges in a hospital that did not permit abortion. But we have no evidence of discrimination the other way at the present time.

We have been trying to look at this issue in as thoughtful and as careful a way as possible so that we do not inadvertently begin to interfere with people's individual liberties in an attempt to solve this problem. It is not that the problem is not important, but rather, that it is going to take considerable care on our part in the process.

I do not know whether Mrs. Mecklenburg has anything to add or not.

Mrs. **Mecklenburg**. No, Senator.

Dr. **Brandt**. By the way, Senator, back to your earlier question, we will be happy to provide you with some representative reports of activities of grantees in the family involvement area. We have some, and we will be happy to send them up to you, either for the record or just for your own personal information.

Senator **Denton**. Thank you. We would be very interested in them, and I would ask that you forward them.

I have several more questions, Dr. Brandt, which I will address to the administration in writing, and would request a response to these questions within 10 working days. Further, in view of the testimony which one can anticipate and the possible assistance which the administration might be able to give in amplifying their position, I wonder if I could ask a special favor, that either you or Mrs. Mecklenburg be permitted to remain for the rest of the hearing, so that we could have recourse for questions.

Dr. **Brandt**. Certainly—I do not know about Mrs. Mecklenburg, but another committee of the Congress has asked for my participation in a small investigation that they have underway, and that is going to take care of my afternoon.

Senator **Denton**. Well, we appreciate the time you have spent with us, Dr. Brandt.

How about you, Mrs. Mecklenburg?

Mrs. **Mecklenburg**. I will remain.

Senator **Denton**. All right. Thank you both very much for your testimony.

Our next witness, Dr. Pawlewski, is the commissioner of the Iowa State Department of Health. I would like to welcome Dr. Pawlewski, recognizing that his Senator, Senator Grassley from Iowa, has already introduced him.

Dr. Pawlewski, welcome, and you may commence with your statement whenever you are prepared.

STATEMENT OF NORMAN L. PAWLEWSKI, COMMISSIONER, IOWA STATE DEPARTMENT OF HEALTH

Mr. **Pawlewski**. Thank you, Senator.

May I correct. I am not a doctor, although I am the commissioner of health. I was the first non-M.D. commissioner in Iowa.

Senator **Denton**. All right. I apologize for conferring that degree.

Mr. **Pawlewski**. Senator Denton and members of the committee, we are grateful for the opportunity to briefly share with you our thoughts in regard to four of the suggested topics. We have also submitted for the record a summary of Iowa's experience with administering the title X family planning program for 12 years. My staff and I welcome the committee's inquiries pertaining to any aspect of our administration of title X in the past or at present.

We are pleased with the progress we have made in providing health-focused family planning services to low and moderate income women in Iowa. Although these programs have at times been controversial, I believe we have gained the respect and support of many previous critics and opponents of family planning services by keeping Iowa services public health-centered.

We have also adhered to a strict code of ethics in keeping with Federal regulations and congressional intent. The title X dollars allocated to the Iowa State Department of Health Family Planning Program pay for administration of the grants and health services to women, nothing else; nothing that would in any way violate the wishes of Congress as expressed in the law or the direction of the administration as provided for in the regulations.

The Iowa State Department of Health considers the family planning services we promote and administer a vital public health function and necessary for the preservation of health for many of Iowa's low-income women. Although title X accounted for less than 50 percent of all funds expended for these services through our agencies, we are appreciative that Congress has continued their commitment over these last 12 years.

The four topics I will briefly address here today are: placement of the title X program in the Primary Care Block Grant; administration of the title X program within the Department of Health and Human Services; parental involvement in the provision of services to minors, and the need to increase services to low-income families. While we are generally supportive of Block grant funding, there are problems with the Primary Care Block Grant as presently constructed, which would cause us to be nonsupportive of this proposal. To the best of my knowledge, only one or two States have opted to administer the Primary Care Block Grant. There are just too many fishhooks in it to make it attractive to State administration or State legislatures.

Enumerating all the problems associated with States assuming responsibility for the Primary Care Block Grant would take the rest of my time and then some. It is obvious that States want and should receive title X family planning funding. It is equally obvious that tying these funds to a program they are reluctant to take will cause serious difficulties and may interrupt or at best, slow the progress we have made in offering family planning over these last 12 years.

If an alternative to categorical funding of title X is desired, we would offer one which is more direct and palatable to us, and I would guess to most other States.

The current title X regulation contains a section which would allow DHHS to make formula grants directly to the States, in much the same manner as the M&CH grants are made. To our knowledge, this provision has never been used. Instead, DHHS has chosen to make project grants and contracts for family planning services, which in the recent past, numbered more than 200 direct grantees—although in recent years, this has been reduced to 88 grantees, in our opinion, Federal and State program efficiency would be served by reducing this number to 50, 1 for each state. Indeed, the GAO recommended in their 1978 report that title X of the Public Health Service Act be amended so that one organization is designated to plan, coordinate and oversee the provision of federally subsidized family planning services in each State and local area. We would go one step further, by recommending that the funding be limited to State agencies responsible for public health services in each State.

Some of the benefits of such designation would be: the elimination of competition for delegate agencies and territories among grantees; the reduction of funds spent on political activities by grantees; stricter adherence to congressional intent in regard to the kinds, levels, and qualities of services offered; less overall administrative costs; integration with other public health programs aimed at low-income women and families; less chance for the comingling of funds intended for family planning services with other funds intended for services not recognized as health-focused family planning; less of a need for Federal oversight at the regional office—State auditors monitor not only fiscal accountability, but program integrity of State agency administration.

Topic 2. We are well-pleased with and support the administration of the title X program by the Deputy Assistant Secretary of Population Affairs. This has elevated the status of the title X program and reduced the layers of bureaucracy, allowing for regulations and guidance to be initiated more rapidly and with more meaningful State input. We have found the Deputy's office to be more responsive to State needs than the previous Federal agency administrator. Administration of the title X program by DASPA is consistent with the 1981 GAO recommendation.

We believe the move to administration by DASPA has been a step forward. There is no reason to step backward again.

Senator, I can stop right there and insert the rest of my testimony for the record.

Senator DENTON. All right. Thanks a lot, Mr. Pawlewski. With a name like yours, I am very tempted to say "Doctor."

[The prepared statement of Mr. Pawlewski and responses to questions submitted by Senator Denton follows:]

ORAL TESTIMONY BEFORE THE SUBCOMMITTEE

ON FAMILY AND HUMAN SERVICES,

COMMITTEE ON LABOR AND HUMAN RESOURCES,

U.S. SENATE - THURSDAY, APRIL 5, 1984,

IN SD 430, DIRKEN SENATE OFFICE BUILDING

BY NORMAN L. PAWLEWSKI, COMMISSIONER

IOWA STATE DEPARTMENT OF HEALTH

INTRODUCTION

SENATOR GRASSLEY, I APPRECIATE YOUR INVITATION TO APPEAR BEFORE THIS COMMITTEE TODAY. SENATOR DENTON, MEMBERS OF THE COMMITTEE, WE ARE GRATEFUL FOR THE OPPORTUNITY TO BRIEFLY SHARE WITH YOU OUR THOUGHTS IN REGARD TO FOUR OF THE SUGGESTED TOPICS. WE HAVE ALSO SUBMITTED FOR THE RECORD A SUMMARY OF IOWA'S EXPERIENCE WITH ADMINISTERING A TITLE X FAMILY PLANNING PROGRAM FOR 12 YEARS. MY STAFF AND I WELCOME THIS COMMITTEE'S INQUIRIES PERTAINING TO ANY ASPECT OF OUR ADMINISTRATION OF TITLE X IN THE PAST OR AT PRESENT. WE ARE PLEASED WITH THE PROGRESS WE HAVE MADE IN PROVIDING HEALTH FOCUSED FAMILY PLANNING SERVICES TO LOW AND MODERATE INCOME WOMEN IN IOWA. ALTHOUGH THESE PROGRAMS HAVE AT TIMES BEEN CONTROVERSIAL, I BELIEVE WE HAVE GAINED THE RESPECT AND SUPPORT OF MANY PREVIOUS CRITICS AND OPPONENTS OF FAMILY PLANNING SERVICES BY KEEPING IOWA SERVICES PUBLIC HEALTH CENTERED. WE ALSO HAVE ADHERED TO A STRICT CODE OF ETHICS, IN KEEPING WITH FEDERAL REGULATIONS AND CONGRESSIONAL INTENT. THE TITLE X DOLLARS, ALLOCATED TO THE IOWA STATE DEPARTMENT OF HEALTH FAMILY PLANNING PROGRAM PAY FOR ADMINISTRATION OF THE GRANT AND HEALTH SERVICES TO WOMEN, NOTHING ELSE; NOTHING THAT WOULD IN ANY WAY VIOLATE THE WISHES OF CONGRESS AS EXPRESSED IN THE LAW OR THE DIRECTION OF THE ADMINISTRATION AS PROVIDED FOR IN THE REGULATIONS.

THE IOWA STATE DEPARTMENT OF HEALTH CONSIDERS THE FAMILY PLANNING SERVICES WE PROMOTE AND ADMINISTER, A VITAL PUBLIC HEALTH FUNCTION AND NECESSARY FOR THE PRESERVATION OF HEALTH FOR MANY OF IOWA'S LOW INCOME WOMEN. (I STRESS LOW INCOME BECAUSE 81% OF THE NEARLY 25,000 WOMEN WE SERVED IN 1983 WERE BELOW 150% OF THE POVERTY LEVEL). ALTHOUGH TITLE X ACCOUNTED FOR LESS THAN 50% OF ALL FUNDS EXPENDED FOR THESE SERVICES THROUGH OUR AGENCIES (47% - 1983 - 50% 1982), WE ARE APPRECIATIVE THAT CONGRESS HAS CONTINUED THEIR COMMITTMENT FOR THESE LAST 12 YEARS.

THE FOUR TOPICS I WILL BRIEFLY ADDRESS HERE TODAY ARE:

1. PLACEMENT OF THE TITLE X PROGRAM IN THE PRIMARY CARE BLOCK GRANT.
2. ADMINISTRATION OF THE TITLE X PROGRAM WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.
3. PARENTAL INVOLVEMENT IN THE PROVISION OF SERVICES TO MINORS.
4. THE NEED TO INCREASE SERVICES TO LOW INCOME FAMILIES

TOPIC 1.....PLACEMENT OF THE TITLE X PROGRAM IN THE PRIMARY CARE BLOCK GRANT

WHILE WE ARE GENERALLY SUPPORTIVE OF BLOCK GRANT FUNDING THERE ARE PROBLEMS WITH THE PRIMARY CARE BLOCK GRANT AS PRESENTLY CONSTRUCTED WHICH WOULD CAUSE US TO BE NON-SUPPORTIVE OF THIS PROPOSAL. TO THE BEST OF MY KNOWLEDGE ONLY ONE OR TWO STATES HAVE OPTED TO ADMINISTER THE PRIMARY CARE BLOCK GRANT. THERE'S JUST TOO MANY FISH HOOKS IN IT TO MAKE IT ATTRACTIVE TO STATE ADMINISTRATION OR STATE LEGISLATURES. ENUMERATING ALL THE PROBLEMS ASSOCIATED WITH STATES ASSUMING RESPONSIBILITY FOR THE PRIMARY CARE BLOCK GRANT WOULD TAKE THE REST OF MY TIME AND THEN SOME. IT'S OBVIOUS THAT THE STATES WANT AND SHOULD RECEIVE TITLE X FAMILY PLANNING FUNDING; IT'S EQUALLY OBVIOUS THAT TYING THOSE FUNDS TO A PROGRAM THEY ARE RELUCTANT TO TAKE WILL CAUSE SERIOUS DIFFICULTIES AND MAY INTERRUPT OR AT BEST SLOW THE PROGRESS WE'VE MADE IN OFFERING FAMILY PLANNING OVER THESE LAST 12 YEARS.

IF AN ALTERNATIVE TO CATEGORICAL FUNDING OF TITLE X IS DESIRED, WE WOULD OFFER ONE WHICH IS MORE DIRECT AND PALATABLE TO US AND I WOULD GUESS MOST OTHER STATES.

THE CURRENT TITLE X LEGISLATION CONTAINS A SECTION 1002 (300A) WHICH WOULD ALLOW DHHS TO MAKE FORMULA GRANTS DIRECTLY TO THE STATES, IN MUCH THE SAME MANNER AS THE M&CH GRANTS ARE MADE. TO OUR KNOWLEDGE THIS PROVISION HAS NEVER BEEN USED. INSTEAD DHHS HAS CHOSEN TO MAKE PROJECT GRANTS AND CONTRACTS FOR FAMILY PLANNING SERVICES WHICH IN THE RECENT PAST NUMBERED MORE THAN 200 DIRECT GRANTEES. ALTHOUGH IN RECENT YEARS THIS HAS BEEN REDUCED TO 88 GRANTEES, IN OUR OPINION, FEDERAL AND STATE PROGRAM EFFICIENCY WOULD BE SERVED BY REDUCING THIS NUMBER TO

50 - ONE FOR EACH STATE. INDEED, THE GAO RECOMMENDED IN THEIR 1978 REPORT ENTITLED "BETTER MANAGEMENT AND MORE RESOURCES NEEDED TO STRENGTHEN FEDERAL EFFORTS TO IMPROVE PREGNANCY OUTCOME", THAT TITLE X OF THE PUBLIC HEALTH SERVICE ACT BE AMENDED SO THAT ONE ORGANIZATION IS DESIGNATED TO PLAN, COORDINATE AND OVERSEE THE PROVISION OF FEDERALLY SUBSIDIZED FAMILY SERVICES IN EACH STATE AND LOCAL AREA. (PAGE 130).

WE WOULD GO ONE STEP FURTHER BY RECOMMENDING THAT THE FUNDING BE LIMITED TO THE STATE AGENCY RESPONSIBLE FOR PUBLIC HEALTH SERVICES IN EACH STATE. SOME OF THE BENEFITS IN SUCH A DESIGNATION WOULD BE:

A) THE ELIMINATION OF COMPETITION FOR DELEGATE AGENCIES AND TERRITORIES AMONG GRANTEES.
B) THE REDUCTION OF FUNDS SPENT ON POLITICAL ACTIVITIES BY GRANTEES.
C) STRICTER ADHERENCE TO CONGRESSIONAL INTENT IN REGARD TO THE KINDS, LEVEL AND QUALITY OF SERVICES OFFERED.
D) LESS OVERALL ADMINISTRATIVE COSTS
E) INTEGRATION WITH OTHER PUBLIC HEALTH PROGRAMS AIMED AT LOW INCOME WOMEN AND FAMILIES.
F) LESS CHANCE FOR THE CO-MINGLING OF FUNDS INTENDED FOR FAMILY PLANNING SERVICES WITH OTHER FUNDS INTENDED FOR SERVICES NOT RECOGNIZED AS HEALTH FOCUSED FAMILY PLANNING.
G) LESS OF A NEED FOR FEDERAL OVERSIGHT AT THE REGIONAL OFFICE LEVEL. STATE AUDITORS MONITOR NOT ONLY FISCAL ACCOUNTABILITY BUT PROGRAM INTEGRITY OF STATE AGENCY ADMINISTRATION.

ADDITIONALLY, WE WOULD RECOMMEND THAT THE TITLE X TRAINING FUNDS WHICH ARE CURRENTLY ALLOCATED SEPARATELY FROM PATIENT SERVICES BE INCLUDED IN THE FORMULA GRANTS TO STATES. THIS WOULD INCREASE THE FLEXIBILITY OF THE STATES TO RESPOND TO ITS MANAGEMENT NEEDS AND MAXIMIZE THE BENEFITS OF THESE FUNDS. A PERCENTAGE OF TOTAL PROGRAM COSTS COULD BE IDENTIFIED AS THE MAXIMUM ALLOWED FOR TRAINING, MUCH LIKE WE CURRENTLY HAVE FOR ADMINISTRATIVE COSTS.

TOPIC 2.....ADMINISTRATION OF THE TITLE X PROGRAM WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

WE HAVE BEEN WELL PLEASED WITH AND SUPPORT THE ADMINISTRATION OF THE TITLE X PROGRAM BY THE DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS. THIS HAS ELEVATED THE STATUS OF THE TITLE X PROGRAM AND REDUCED THE LAYERS OF BUREAUCRACY, ALLOWING FOR REGULATIONS AND GUIDANCE TO BE INITIATED MORE RAPIDLY AND WITH MORE MEANINGFUL STATE INPUT. WE HAVE FOUND THE DEPUTY'S OFFICE TO BE MORE RESPONSIVE TO STATE NEEDS THAN THE PREVIOUS FEDERAL AGENCY ADMINISTRATOR. ADMINISTRATION OF THE TITLE X PROGRAM BY DASPA IS CONSISTENT WITH 1981 GAO RECOMMENDATION:

> "TO PUT THE DEPUTY IN A BETTER POSITION TO COORDINATE AND EVALUATE ALL FAMILY PLANNING ACTIVITIES WITHIN HHS, . . ."

A FEW EXAMPLES OF THE IMPROVED [illegible] ADMINISTRATION WE'VE EXPERIENCED UNDER DASPA OVER THE PAST YEAR ARE:

A) A REPRESENTATIVE OF THE DASPA, IN CONJUNCTION WITH EACH REGIONAL OFFICE, PARTICIPATED IN REGIONAL MEETINGS OF GRANTEES TO RECEIVE INPUT ON ISSUES AND DIRECTIONS OF THE PROGRAM.

B) ADVISORY GROUPS HAVE BEEN ESTABLISHED BY THE DASPA FOR SERVICE DELIVERY IMPROVEMENT AND DATA COLLECTION.

C) THE DASPA HAS ESTABLISHED A CONTRACTUAL RELATIONSHIP WITH THE DIVISION OF REPRODUCTIVE HEALTH, CENTERS FOR DISEASE CONTROL TO PROVIDE FOR UTILIZATION

OF CDC'S EXPERTISE IN DATA COLLECTION AND ANALYSIS, COMPUTERIZED PATIENT FLOW ANALYSIS, AND THE DEVELOPING OF RECOMMENDATIONS ON PRODUCTIVITY MEASURES. THIS WILL BE HELPFUL TO GRANTEES IN IMPROVING THEIR PROGRAMS.

WE BELIEVE THE MOVE TO ADMINISTRATION BY DASPA HAS BEEN A STEP FORWARD. THERE IS NO REASON TO STEP BACKWARD AGAIN.

TOPIC 3.....PARENTAL INVOLVEMENT IN THE PROVISION OF SERVICES TO MINORS

WE SUPPORT THE PHILOSOPHY THAT ADOLESCENTS BE ENCOURAGED TO INVOLVE THEIR PARENTS IN THEIR DECISION TO RECEIVE FAMILY PLANNING SERVICES AS WELL AS PROVIDE AN OPPORTUNITY FOR PARENTS TO PARTICIPATE. WE ARE GENERALLY PLEASED WITH THE ATTITUDE AND THE EFFORTS OF OUR LOCAL AGENCIES IN SHARING THIS PHILOSPHY. WE ARE, HOWEVER, RELUCTANTLY OPPOSED TO PARENTAL NOTIFICATION OR CONSENT AS A REQUIREMENT FOR ADOLESCENTS TO RECEIVE FAMILY PLANNING SERVICES. DURING THE PAST CALENDAR YEAR, 16% OF THE PATIENTS RECEIVING FAMILY PLANNING SERVICES THROUGH THE STATE OF IOWA PROGRAM WERE AGE 17 OR LESS. AGENCIES INDICATE THAT TEENS HAVE BEEN SEXUALLY ACTIVE FOR A FEW MONTHS BEFORE DECIDING TO RECEIVE CONTRACEPTIVE CARE, AND FREQUENTLY, IT'S A PREGNANCY SCARE WHICH PROMPTS THEIR ACTION.

AS THE FATHER OF A YOUNG LADY OF 18, I WOULD BE MORE THAN A LITTLE UPSET IF SHE HAD AT ANY AGE BETWEEN ELEVEN AND NOW SOUGHT OUT AND RECEIVED PRESCRIPTION CONTRACEPTIVE DRUGS WITHOUT MY KNOWLEDGE. I WOULD CONSIDER SUCH A SERVICE AN AFFRONT TO MY PARENTAL PEROGATIVE. I WOULD, HOWEVER, ALSO CONSIDER IT A FAILURE ON MY PART, TO BE OPEN TO COMMUNICATING WITH MY DAUGHTER REGARDLESS OF HOW DISTASTEFUL OR PAINFUL THE SUBJECT OF THAT COMMUNICATION MIGHT BE.

ON THE OTHER HAND, AS A PUBLIC HEALTH PROFESSIONAL FOR OVER 22 YEARS, I'M WELL AWARE OF THE HEALTH RISKS INVOLVED IN TEENAGE PREGNANCY AND THE EVEN GREATER PHYSICAL AND EMOTIONAL RISKS ASSOCIATED WITH ABORTIONS WHICH ARE ALL TOO OFTEN RECOMMENDED AS A SOLUTION TO AN UNPLANNED TEENAGE PREGNANCY. ON THE BASIS OF RISK-BENEFIT ANALYSIS I MUST OPT FOR PATIENT CONFIDENTIALITY IF PARENTAL

NOTIFICATION WOULD HINDER THE SEEKING OUT AND UTILIZATION OF PREVENTIVE SERVICES. IN THIS CASE, WHAT I KNOW IS RIGHT (PARENTAL NOTIFICATION OF CONTRACEPTIVE PRESCRIPTIONS) MUST BE SUBJACENT TO WHAT I KNOW IS PRUDENT FROM A PUBLIC HEALTH PERSPECTIVE. I WOULD NOT, HOWEVER, EXTEND MY LIBERALITY TO ANY SURGICAL PROCEDURES, WERE THEY A PART OF THIS TITLE. THEY ARE NOT, HOWEVER, AND FOR THAT I AM GRATEFUL.

TOPIC 4.....THE NEED TO INCREASE SERVICES TO LOW-INCOME FAMILIES

FAMILY PLANNING CLINICS PROVIDE SERVICES WHICH DIRECTLY CONTRIBUTE TO THE IMPROVEMENT OF PUBLIC HEALTH INDICATORS. THE IMPROVED HEALTH STATUS OF WOMEN IN THE CHILDBEARING YEARS WILL DIRECTLY INFLUENCE THE HEALTH OF THE INFANTS THEY BEAR AND WILL INFLUENCE THE FUTURE COSTS OF HEALTH CARE AS THESE WOMEN PASS FROM CHILDBEARING INTO THE POST-MENOPAUSAL AND ELDERLY STAGES OF LIFE.

THESE GOALS ARE NOT MET BY SIMPLY PROVIDING THE CONTRACEPTIVE SERVICES NEEDED TO SPACE PREGNANCIES AT OPTIMAL INTERVALS, ALTHOUGH THIS IS THE LARGEST COMPONENT OF THE FAMILY PLANNING EFFORT. FAMILY PLANNING CLINICS ALSO PROVIDE A WIDE RANGE OF SCREENING SERVICES AS A PART OF DETERMINING APPROPRIATE CONTRACEPTIVE CARE. EXAMPLES OF HEALTH STATUS DATA ROUTINELY GATHERED BY FAMILY PLANNING STAFF ARE

1) RUBELLA IMMUNIZATION STATUS
2) FAMILY HISTORY OF CARDIOVASCULAR DISEASE, DIABETES AND CANCER
3) HYPERTENSION SCREENING
4) ANEMIA SCREENING
5) NUTRITIONAL RISKS SUCH AS HIGH/LOW WEIGHTS/HEIGHTS
6) CERVICAL CANCER
7) BREAST CANCER, AND
8) SEXUALLY TRANSMITTED DISEASES.

THE PROBLEM FACING FAMILY PLANNING CLINICS IS HOW TO PROVIDE MEDICAL SERVICES TO THE LOW-INCOME FAMILIES WHEN A PROBLEM IS IDENTIFIED. SOME NEEDS CAN BE MET

THROUGH INTEGRATION WITH OTHER PUBLIC HEALTH EFFORTS. IN MANY CASES, HOWEVER, PATIENTS ARE UNABLE TO RECEIVE SIMPLE TREATMENTS OR SERVICES BECAUSE PRIVATE SECTOR CARE IS TOO COSTLY AND ELIGIBILITY CRITERIA FOR OTHER PROGRAMS EXCLUDES THEM. FAMILY PLANNING CLINICS COULD EXTEND PROTOCOLS TO PROVIDE THESE SERVICES AT VERY MINIMAL COSTS, BUT ONLY WITH ADDITIONAL ASSISTANCE FROM PUBLIC HEALTH RESOURCES, INCLUDING ADDITIONAL FUNDS.

THERE IS ALSO A NEED FOR SCREENING SERVICES, PARTICULARLY CANCER SCREENING, FOR LOW-INCOME WOMEN WHO ARE NO LONGER IN THEIR CHILDBEARING YEARS BUT WHO ARE INELIGIBLE FOR TITLES XVIII AND XIX OF THE SOCIAL SECURITY ACT. THIS IS ANOTHER PUBLIC HEALTH SERVICE NEED THAT COULD BE READILY INCORPORATED INTO THE TITLE X PROGRAM IF ADEQUATE RESOURCES WERE AVAILABLE.

SENATOR, THE FAMILY PLANNING SERVICES PROVIDED UNDER TITLE X ARE NOT ONLY COST EFFECTIVE, THEY ARE DESPERATELY NEEDED BY THE WOMEN AND FAMILIES WE SERVE AND BY THOSE WE HAVE NOT YET SERVED. IN MY STATE I WOULD BE CONSIDERED BY MOST A FISCAL AND POLITICAL CONSERVATIVE. IT IS BECAUSE I AM CONSERVATIVE THAT I SUPPORT THE PROVISION OF THESE SERVICES. THEY DON'T COST, THEY PAY IN HEALTHIER MOTHERS, HEALTHIER CHILDREN AND SOMETIMES IN HEALTHIER FAMILIES.

THANK YOU FOR YOUR TIME AND CONSIDERATION OF OUR VIEWS.

WRITTEN SUPPLEMENT TO ORAL TESTIMONY

TOPIC 5 . . . . . RESPONSE TO GOVERNMENT ACCOUNTING OFFICE REPORT ON THE OPERATION OF THE FAMILY PLANNING PROGRAM.

The BCRR (Bureau of Common Reporting Requirements) has been used since Calendar Year 1977 to collect patient characteristics services, and financial information from each grantee. Initially, there was a single firm used for technical assistance to regions and grantees which provided for some degree of standardization. A sample of grantees were to be audited on an annual basis for the accuracy and completeness of the data submitted. To our knowledge, this has never occurred except as reported in the 1981 GAO report.

There continues to be a need for patient and service definitions to be clarified so as to allow for objective comparison of grantees, program analysis, and policy development. There is a variance by grantees and regions in the completion of their BCRR reports and feedback on the data collected has been minimal. This variance needs to be corrected and information needs to be shared with the grantees on a routine basis.

WRITTEN SUPPLEMENT TO ORAL TESTIMONY

DESCRIPTION OF THE GRANTEE

The Iowa State Department of Health began providing funding for family planning services to patients at prenatal and postpartum clinic visits in the late 1960's. Department funds went to the University of Iowa who channelled these monies to satellite clinics in Waterloo, Cedar Rapids, Davenport and Muscatine, and to the Council Bluffs Maternal Health Center. The Department also provided funds to Planned Parenthood of Iowa to expand family planning services at the Des Moines Clinic and in rural areas.

In 1970, a national shift of family planning funds occurred, transferring them from the Office of Economic Opportunity to the Public Health Service. Iowa responded to this national change by having the Iowa State Department of Health designated as the grantee recipient of family planning funds for the State in 1972. Through its existing network of linkages with State and local agencies, the Department was in an ideal position to provide a statewide service. It was with this commitment that, in 1972, the Iowa State Department of Health began to administer the Statewide Family Planning Program under enabling legislation and funding of the Public Health Act.

Beginning in October, 1980, another umbrella grantee was funded to provide family planning services. Seven delegate agencies previously under contract with the

Department now receive their funding through the Family Planning Council of Iowa. The Iowa Family Planning Program currently provides services in 59 of Iowa's 99 counties through contracts with 11 separate agencies. All but five of the counties covered are rural.

The Program is housed within the Division of Personal and Family Health which also administers Maternal and Child Health Programs, Dental Health Programs, and the WIC Program. To assure input from the delegate agencies, an advisory group consisting of the director of each agency meets at least quarterly. This group helps the Program with Planning and procedures for the administration of the Program. The directors also serve on special committees such as training/technical assistance, funding and data.

SERVICES PROVIDED

General Assurances

Family Planning services are provided in a manner assuring comprehensiveness and continuity in the management and supervision of service delivery. Each agency is required to have medical policies that meet, as a minimum, the State's uniform medical policy. This policy was written to meet the standards set by the Title X regulations/guidelines and the American College of Obstetrics and Gynecology.

The local delegate agencies each have their individual medical directors who have special training or experience in family planning. He or she establishes the medical direction of the local program within the scope of the State program. The Iowa Family Planning Program utilizes the Maternal & Child Health Medical

Director as its medical director. To compliment this, special consultation is also available from the University of Iowa, Department of Obstetrics and Gynecology, as well as a specialist in adolescent health.

The State Program continues to utilize a broad advisory committee for review of informational and educational materials for the handicapped population served by the Program. It includes teachers, parents, psychologist, mental health professionals and deaf services professionals. Each local agency also has an Information and Educational Materials Review Committee to assure that informational and educational materials used by the agency are accurate, easily understood and acceptable to the community.

The patient's rights with regard to this service are also assured. The service is provided to anyone, regardless of age, sex, race, national origin, religion, handicapping condition or marital status. Patient rights of confidentiality are protected.

The Iowa Family Planning Program is firmly committed to the concept of informed consent, for ethical, medical and legal reasons. An informed consent to receive the project's services must be signed by the client prior to his or her receiving any medical services. The form is written in the primary language of the client or witnessed by an interpreter. It covers all procedures and medications to be provided. To give informed consent for contraception, the client receives education on the benefits and risks of the various contraceptive alternatives and details on the safety, effectiveness, potential side effects, complications, and danger signs of the contraceptive method(s) of choice. Patients are encouraged to ask questions. Forms for each contraceptive method, including sterilization, are a part of the project's service plan. All forms contain a statement that the client has been counseled, has read the appropriate informational material, and has understood the content of both. The signed informed consent is a part of the client's record. It is renewed and updated when there is a major change in the client's health status or a change to a different prescription contraceptive method.

Patient Services

The Iowa Family Planning Program interprets the intent of Title X of the Public Health Service Act as the provision of medical family planning services. Patient education (family planning counseling) is an important part of our mission to enable individuals to plan pregnancies, but as a single service falls short of our goals. Therefore, we developed the definition of the Full Program Patient (FPP), and focus was directed toward serving as many of these individuals as possible.

A Full Program Patient receives all of the following services. These services are the minimum requirements of the Title X regulations.

1) family planning counseling
2) lab services
3) physical exam
4) provision of a contraceptive method, infertility services (Level I), or sterilization counseling. All methods of contraception, including natural family planning, are available at our family planning agencies.

Partial services are provided to those individuals who request them. Agencies are encouraged to emphasize services to the low-income population. During Calendar Year 1983, the Program served 24,596 users of which 81% were below 150% poverty level.

Parental Involvement

One of the Federal initiatives in family planning recently has been that of encouraging parental involvement in family planning services to teens. This is a difficult area to address because of the preceived conflict between the needs of the teens to confidential services and the needs of parents to be involved in the rearing of their children.

The Iowa Family Planning Program approaches the issue of parental involvement in two ways. The first is to counsel teenage patients on the importance of involving their parents or another significant adult in their contraceptive care. Each clinic has, as part of their counseling protocol, a procedure for providing this information. The clinics also strive to provide a non-threatening atmosphere to foster comfort in sharing information with teens and their parents.

The second mechanism is to assist parents in communicating with their children about sexuality. Each agency has programs designed to inform parents about sexuality, family planning, and/or values clarification.

The Department plans, subject to the availability of funds for next year, to contract with the State PTA and March of Dimes Organizations to conduct parent seminars around the State through the use of community volunteers as a complement to the family planning agencies.

DESCRIPTION AND EXPERIENCE OF GRANTEE

The Family Planning Program, along with the Maternal and Child Health, WIC, and Dental Health Programs of the Department, has participated in the development and implementation of the numerous integration efforts. An integrated Grant Application was implemented this year, which allows local agencies having one or more of the aforementioned programs to submit only one grant application. A combined expenditure report was also implemented which allows for these agencies to file a single, comprehensive expenditure report for these same programs. A quality-assurance, uniform chart audit protocol is being developed for use by all the Programs this fall. The Programs in the Department's Division of Personal & Family Health have developed a generic approach to training agency (local and state) staff to address common needs while allowing for program specific training to occur.

FUNDING

The Iowa Family Planning Program supports all of its activities with Title X (Federal Family Planning) dollars. During CY 1983, these expenditures comprised 13% of all available Title X dollars. The remainder is allocated to the delegate agencies for the purposes of providing direct family planning services.

The delegate agencies generate program income from other sources: Social Services Block Grant (Title XX), Medicaid (Title XIX), patient fees, County Board of Supervisors, insurance and contributions/local support. Title X comprises 47% of the funds spent on family planning services provided through the Iowa Family Planning Program. Direct State administration costs are 5% of the total spent.

State funds ($59,000) for FY84 were added to the federal funds of Social Services Block Grant (formerly Title XX) so that a total of $300,000 was identified for use for local family planning services.

ELIGIBILITY

Family Planning services are provided without regard to age, marital status, race, or sex. Low-income persons are a priority in recruitment and provision of services. However, provision of services to persons above poverty is done in a manner so as not to create a barrier to service nor prevent provision of services to low-income individuals.

Income guidelines are determined by the Community Services Administration of the Federal Government. Eligibility for free service has been set at 100% of poverty, per Title X requirements dated June 3, 1980.

Fee Schedules

Patients with incomes below the income eligibility guidelines or those whose services are reimbursable through Medicaid, private insurance, or Title XX are not asked to pay for services. Patients with incomes above guideline levels and without third-party reimbursement are asked to pay a fee for service commensurate with their ability to pay. Each agency is responsible for the establishment of a sliding fee schedule based on costs of services provided. No one is denied service because of inability to pay. Sliding fee schedules are applied flexibly, taking into account seasonal unemployment, student status, access to family income and other constraints upon the availability of funds; they are updated annually and reviewed by State staff during the on-site evaluation of the agency.

The fee schedules are based on increments between 100% and 250% of poverty. Individuals with incomes over 250% of poverty are asked to pay the full cost of service. All services to family planning patients are provided with a schedule of discounts.

Beginning January 1, 1983, the Iowa Family Planning Program initiated a policy regarding fees for teens. This policy was approved by the Regional Office. It allows agencies to consider the financial base of parental support and the discretionary income of the teen in determining financial eligibility.

In order to determine whether or not this policy was beneficial to the agencies, a brief analysis was done at the end of CY 1983, the first full year of this policy. During CY82, 95% of patients under 20 years of age were at or below 150% of poverty; for CY83 this figure was 94%. It was determined that the new policy was not, in fact, placing teens into higher fee-paying categories.

On the other hand, prior to the new policy, agencies were automatically charging all teen visits to Title X. Although data are not kept by age, visit and payment status, the Program does track visits by payment source. When visits were compared for Quarter 4 of CY 1982 to Quarter 4 of CY 1983, we found a 10% change in the number of visits billed to the Partial Pay category, from 49% to 59%. It could be inferred, then, that agencies have improved their ability to receive some fees from the teens with larger discretionary incomes, and that the policy has not created a barrier to provision of services to the teen population.

BULK PURCHASE CONTRACTS

The Program has bulk purchase contracts for several services/supplies. The Department entered into these contracts in order to reduce the cost to the local agencies by virtue of the larger size of a single contract and the reduction in billing work for the supplier.

The savings realized by these contracts are significant. Private purchase of cytology for pap smears could have cost the Program an additional $70,000/year. During FY83, it is estimated that the cost of condoms was reduced by 28% and the cost of pregnancy tests by 51%. The oral contraceptive bulk contract represents a savings of 30% over the prices quoted to the local agencies, or a potential dollar savings of nearly $75,000/year.

PROGRAM STATISTICS

The following provides for a comparison of program statistics, funding, BCRR indicators, and patient characteristics. The Program developed and maintains a computerized patient data system for collection of the majority of the data. This system also serves as a payment mechanism to the agencies, and also acts as a tool for documenting services during the on-site evaluations of the agencies.

PROGRAM STATISTICS

	CY83	CY82
# Full Program Patients	19,623	18,570
# Low Income Full Program Patient (≤100%)	12,662	12,346
# Users	24,596	24,426
# Users 150% Poverty	20,064	20,836
Cost/Full Program Patient	$83.74	$98.36
Cost/User	$66.81	$74.78
Cost/Medical Encounter	$18.50	$21.40
Title X Cost/ Low Income User	$33.14	$39.20

FUNDING

	CY83		CY82	
	$	%	$	%
Title X	664,929	47	816,939	50
Title XIX	126,507	9	110,787	7
Title XX	106,539	7	101,773	6
Patient Fees	323,037	23	258,900	16
Other	201,746	14	361,935*	21
TOTAL	1,422,758	100%	1,650,324	100%

*Includes Title V in CY82

BCRR INDICATORS

	C.Y.83	C.Y.82	Standard
Administrative Cost TOTAL = STATE ONLY =	 15% 5%	 16% 5%	 16% Maximum
Provider Productivity =	8,803	6,984	4,200 Minimum
Cost/Medical Encounter =	$18.50	$21.40	$24.00 Maximum
Hypertension Screening =	99%	100%	90% Minimum
Pap Smear Follow-up =	100%	100%	100% Minimum
Family Planning Counseling =	99%	99%	90% Minimum

PATIENT CHARACTERISTICS

	CY83	CY82
Were under 18 years of age	16.2%	18.1%
Were aged 18-19	22.9%	23.7%
Were aged 20-34	58.9%	56%
Were aged 35-44	1.78%	1.8%
Were female	99.8%	99.8%
Were white	95.2%	94.8%
Had less than 9 years of education	3.2%	3.6%
Had 9-11 years of education	25.2%	28.3%
Had 12 years of education	55.0%	52.8%
Had more than 12 years of education	16.5%	15.4%
Were using oral contraceptives at last method prescribed	75.9%	74.3%
Had no live births	64.8%	64.5%
Had 1 or 2 live births	29.7%	29.8%
Had 3 or 4 live births	4.7%	4.8%

RESPONSES BY COMMISSIONER PAWLEWSKI TO THE QUESTIONS SUBMITTED BY SENATOR DENTON

1. Senator Denton, we feel the steps that we have taken to encourage parental involvement could be easily replicated by other family planning providers. Attachment 1 describes what we do.

2. As for your question concerning political advocacy by non-public grantees of the sort detailed in 1982 GAO report, I would say yes this has occurred in Iowa. Attachment 2 describes the situation which occurred during the last General Assembly which prompted the Department to provide a position statement for the Legislature.

   Subsequent events not reflected in Attachment 2 were:
   1) The passage of the appropriations bill for the Department of Health in May containing a condition for the Department to release the federal funds for the 3 agencies.
   2) The Governor of Iowa exercised a line item veto of the bill, removing the condition.
   3) Nine legislators filed a lawsuit against the Governor for his exercise of the line item veto. Litigation is still pending. One of the lawyers involved has been past legal counsel to Planned Parenthood of Mid-Iowa, which also contracts with a legislative lobbyist.
   4) Attachment 3 is included as an example of Planned Parenthood's political involvement.

3. The Association of State and Territorial Health Officers (ASTHO) met April 25-26, 1984 in Little Rock, Arkansas. During that meeting, I asked for ASTHO to indicate their support of the formula grant for Title X proposed in my testimony to you. I am pleased to report that there was a consensus of support given by the ASTHO members, on the basis that formula grants for Title X would be given to the Health Department of each State. The action is included in the minutes of the ASTHO meeting. A formal action is to be taken by the Executive Committee of ASTHO once they receive a copy of my testimony. Attachment 4 explains the Title V formula grants made to States.

ATTACHMENT 1

A. Our current year grant application instructions for our subgrantees required a description of formal linkages/referra and family participation.

1) Describe or include any written agreements with other providers or agencies. Also describe referral, follow-up procedures, and referral arrangements with other agencies Family planning agencies must also have formal linkages within the community for referral of pregnant adolescents to agencies providing needed services such as adoptive agencies, foster homes, prenatal care, and adolescent pregnancy prevention services.
2) Family planning agencies need to describe how they provide for family participation. Describe the counselin protocol for adolescents.

B. Our grant application instructions for the new fiscal year require agencies to do item #1) above. However, item 2) has been revised to:

Family planning agencies need to describe how they currently foster and provide for the involvement of parents and the community in the sexual education and decision-making of minors and how they will increase that involvement in FY85. Also describe the counseling protocol for adolescdents.

C. Uniform Medical Policies

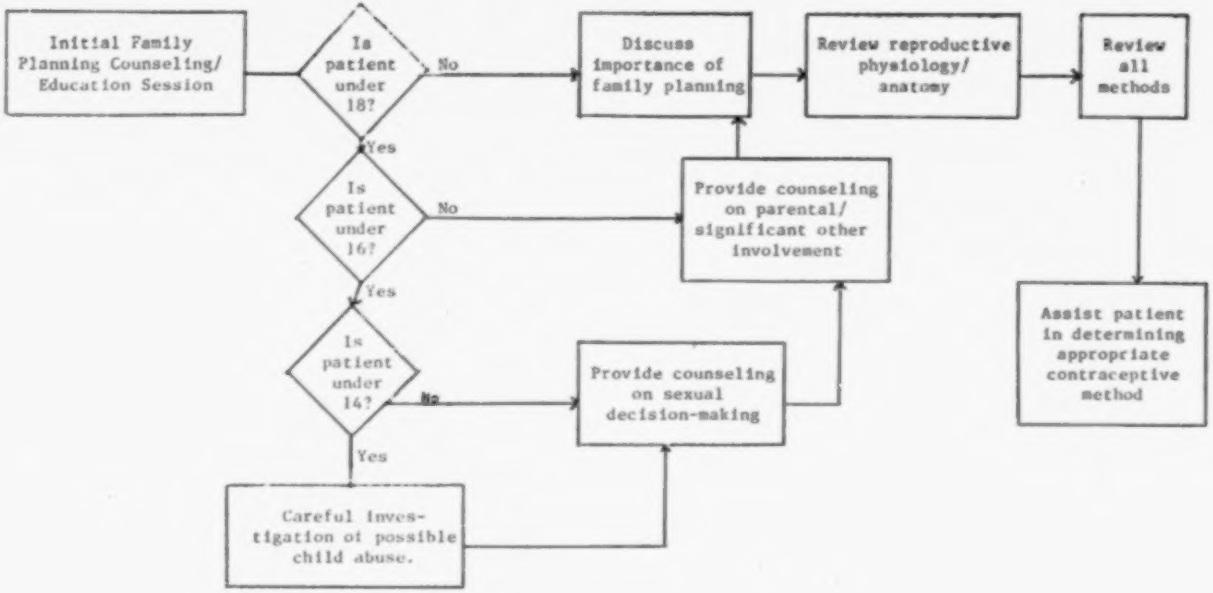
At the State level, the Family Planning Program has uniform medical policies which serve as the minimum guidelines for the medical protocols of each family planning program under contract with the Iowa State Department of Health. Section applying to teens is attached.

D. Formal Evaluation/Monitoring

Each agency is visited annually for an on-site evaluation. The on-site evaluation may be accomplished as one visit or two visits, depending upon scheduling difficulties. An administrative evaluation, a medical evaluation,* and a general evaluation are the components of the on-site visit(s). The checklist used for an Administrative audit is attached.

*The chart audit includes a review of the counseling provided Also the medical policies are reviewed to ensure they are current, meet the minimum guidelines, and include a special counseling protocol for teens.

Initial Visit Counseling
Family Planning Procedure


Initial Family Planning Counseling/ Education Session
Is patient under 18?
No
Yes
Is patient under 16?
No
Yes
Is patient under 14?
No
Yes
Careful investigation of possible child abuse.
Provide counseling on sexual decision-making
Provide counseling on parental/ significant other involvement
Discuss importance of family planning
Review reproductive physiology/ anatomy
Review all methods
Assist patient in determining appropriate contraceptive method

FAMILY PLANNING CARE PROTOCOL

I. Initial Patient Interview and Education Session

At the first visit, before selection of a contraceptive method and prior to the physical exam, the patient will be given bias-free information regarding:

- The reasons why family planning is important for the maintenance of individual and family health.

- Basic information on female and male anatomy and physiology. (This is intended to help the patient make an intelligent choice of contraception method, and dispel any fear or anxiety about family planning.)

- Contraceptive methods
  - Temporary - diaphragm, foam and jelly, condom, coitus interruptus, natural family planning methods, and FDA approved hormonal contraceptive and IUD.
  - Permanent - male and female sterilization

- Specific factors concerning any method's safety (potential side effects or complications), benefits, effectiveness, acceptability to patient and partner, and correct usage.

- Basic information concerning venereal disease.

It is important to distinguish the differing informational needs of our patients. This is particularly true of patients under the age of 18. For these individuals, the following information is also provided, in a non-judgmental manner:

- The importance of involving parents or significant others in making contraceptive choices

- For younger teens (under 16), counseling on sexual decision-making, self-concept, the right to say "no".

- Child abuse is to be suspected for any teen under the age of 14 and carefully investigated.

ATTACHMENT 2

IOWA STATE DEPARTMENT OF HEALTH
POSITION STATEMENT
ON
FAMILY PLANNING SITUATION

There currently is a situation involving the Family Planning Program that is causing some concern. Essentially, three agencies that currently contract with the Iowa State Department of Health for Family Planning services requested that the Department transfer funds for those geographic areas to a private non-profit organization. The Department's position is that, although local contract agencies should be a part of the managerial process, there are significant factors which as the grantee, the Department must consider above and beyond local choices. Additionally, as a recipient of the Federal dollars, the Department of Health and Human Services defines the options available to ISDH. Therefore, we have determined that it is not in the best interest of ISDH's Family Planning Program to transfer geographic areas and dollars to another umbrella agency.

With this position paper, we hope to present the Department's perspective on this issue and the reasons for our decision.

I. Background on the Two Administrative Agencies

Prior to October 1, 1980, the Iowa State Department of Health was the sole recipient of Title X (Family Planning) monies. This program is a Federal, categorical grant program. On October 1, 1980, a new organization was formed to serve as recipient for Title X funds for six agencies.

The new grantee was funded with the permission of the Commissioner of Health, Norman Pawlewski. During the winter and spring of 1980 relations had become strained between the Department and several family planning agencies. It became evident that the Department would not be able to maintain administrative relations with these agencies due to the emotions and problems on both sides. Commissioner Pawlewski offered to release all or a part of the geographic areas to a new grantee. The eighteen family planning agencies each indicated their preference; six agencies chose to affiliate under a separate grantee. On July 1, 1982, another agency affiliated with the "new" grantee.

II. Iowa State Department of Health's Rationale for Non-transfer

The Department carefully considered the issue of whether or not to transfer the funds for the three service areas under question. The decision was made based upon two general considerations - programmatic and fiscal.

ATTACHMENT 2

The Family Planning Program of ISDH is considered to be an integral part of the public health service network. Family planning is an essential component of the health and well-being of the citizens of Iowa - particularly that of the women and children. Since the Department's charge is to provide for the health of Iowa's citizens, we feel that family planning is a part of our sphere of concern. Therefore, it is legitimate for us to continue providing this service.

The Department considers itself to be a good provider of this service for the following reasons:

1. The ability to integrate family planning with other services, such as maternal health, child health, WIC nutrition programs, sexually transmitted disease prevention, genetic counselling, all of which are currently provided through the Department.

2. The ability to draw upon a wide range of professionals employed by the Department for training and technical assistance.

3. The ability to provide a data base for documenting the need for service, the services provided and to respond to the legislature and the public.

4. The ability to assure sound fiscal and program management through the Comptroller and State Auditor.

For these philosophical reasons, the Department wishes to maintain the program in a viable form. The practical considerations of the transfer are as follows.

For FY84, the ISDH program was told that funding would be $681,908 for the current service area. According to the budget submitted, we would have a full time equivalency of 3; 1.8 of which would be for administration. A total of 8% of the funds would be for administrative purposes.

Our calculation of the amount that would be transferred is $245,704. If we transferred thos geographic areas, we would have a remaining grant amount of $436,204.

$681,908
-245,704
$436,204

With the proposed transfer, the Department would still have responsibility for eight geographic areas/contract agencies. If we had 8% of the funds for administration (which is the standard amount we attempt to achieve), the Department would have a total of $34,896 for that purpose. This would be less than one full-time professional employee, and less than a half-time clerical employee to attend to all the administrative duties required by sound management practices and by Federal Regulations. The Department feels that this amount of funding would be inadequate and therefore would, of necessity, cause us to be unable to assure meeting the needs of the remaining eight agencies. These agencies have stated their current preference for ISDH management, and do not want to lose our advocacy and support. In addition, these agencies to a large extent cover geographic areas with few service choices and great economic needs.

Therefore, in the interest of serving these people, and maintaining a high-quality service to the low-income women of Iowa, the Department has chosen not to transfer funds. We have indicated our willingness to continue contracting with the three agencies in question; if they choose not to renew their contracts, the Department will find new contractors to provide subsidized family planning services in those areas. Under no circumstances will the Department deny federal funds to any geographic area for which we are responsible.

III. Analysis and Conclusions

Three years ago all family planning agencies in the State of Iowa were given the option by this Department to choose the umbrella with whom they wished to associate. The geographic assignments of the two umbrellas were determined as a result of those individual agency choices. From that point on, this Department has assumed a non-competitive stance, working on the belief that a compromise had been achieved.

Essentially, these three agencies have decided to raise the issue of affiliation three years after the basic issues were thought to be resolved. This is their prerogative, of course; however, the funds are not theirs to transfer. Title X funds are granted to ISDH for 59 counties in Iowa. The funds do not belong to the local agency. They are mistakenly attempting to maintain that the geographic assignments of the umbrella should fluctuate according to the agencies' desire to affiliate with one umbrella or the other. Responsible managers cannot support a system which purports that these desires should be the sole basis of determining service areas, depending upon changes in staff or management practice.

We believe these agencies have possibly made decisions based on incomplete information. They asked to change their affiliation, assuming the dollars would transfer with them. Though we informed them that this may not occur and the outcome of such a decision, they chose to submit their names under the Family Planning Council's grant. However, this is a Federal non-competitive cycle, so the FPCI grant was deemed competitive; as a consequence, their grant was returned to them by the Federal Government as unacceptable. As the Title X program is currently constituted, this closes the issue as far as the grant authority (DHHS) is concerned.

We are given to understand, although we have not been personally informed, that these agencies have concerns about management practices of ISDH. Though this Department both seeks and values the input of local agencies, we maintain that we are and should be obligated in Family Planning, as in other public health endeavors, to weigh those concerns against the overall good of the statewide program. Any grantee would (and should) manage a program on this premise. We cannot force an agency to contract with us, nor would that be our wish. We can and have invited these three agencies to reaffiliate with us and to work cooperatively on improving both theirs and our operations. Should they choose not to, we will find other providers or reassign our counties among the eight remaining grantees. It is our hope that these agencies will accept our invitation.

ATTACHMENT 2

APPENDIX A

Sequence of Events - Current situation

July 1, 1982	Both family planning grantees - the ISDH and Family Planning Council of Iowa - were awarded grants for a three-year period. Each grant covers a specific geographic area of the State. These grants are considered non-competititve for the three-year period, ending June 30, 1985.
January 27, 1983	All the Iowa Planned Parenthood affiliates met at Hotel Savery - included agency directors and their respective Board presidents. This event assumes some importance as a consequence of later events.
February 4, 1983	Jill June, Director of the Family Planning Council of Iowa, sent a letter to Regional Office requesting dollars for three ISDH contract agencies. The letter indicates she had already discussed this with Regional Office.
February 8, 1983	Lois Hand of Hillcrest/Dubuque called. Carolyn Adams was out of the office, so returned the call on February 9. Ms. Hand verbally informed ISDH that her agency was considering switching to Family Planning Council of Iowa. Reasons - lobbying advantage and fewer requirements for reporting, etc.
February 11, 1983	Letters from Planned Parenthood of Sioux City and Planned Parenthood of Southeast Iowa received stating they were considering switching to other grantee. Both directors were contacted by phone to ask reasons for concern. Melanie Bohl, PPSC: She didn't like the reporting system, had nothing in common with the rest of the agencies, felt it was important for all the Planned Parenthood affiliates to be under the same umbrella grantee so they could work together. Ana Warner, PPSI: The Planned Parenthood Federation of America was encouraging all affiliates of the State to be under one umbrella. She felt that Planned Parenthood of Mid-Iowa would be able to help her and her Board more if they were together.

ATTACHMENT 2

February 14, 1983	Jill June, James Koolhof (President of FFC,I) the Honorable Dorothy Carpenter, and the Honorable Al Sturgeon met, at their request with the Commissioner, Carolyn Adams, and Dr. Theodore Scurletis of ISDH. The meeting was to ask the Commissioner to assure an orderly transition for the transfer of the three agencies.
February 14, 1983	Carolyn Adams called the Regional and Central Offices of DHHS to clarify ISDH's options concerning the transfer. Verbal response was that for the duration of the grant period we could choose to not transfer geographic areas.
February 16, 1983	Conference call with all 11 agency directors to appraise them of situation and asking them to come in the following week.
February 16, 1983	R.O. 7 letter from Will Marshall to Jill June indicating that they assumed Jill and agencies had talked with ISDH concerning any transfer. Indicates it is two grantees decision.
February 17, 1983	Carolyn Adams and Phyllis Blood met with the Executive Committee of Planned Parenthood of Southeast Iowa. They asked what activities ISDH could do better than the other umbrella. State staff asked for specific information about complaints and concerns but received little concrete examples. Some of PPSI's staff had had problems completing data forms, etc. The Board was told that the State may not transfer the dollars.
February 18, 1983	Family Planning Council of Iowa meeting in Davenport. Board resolved to expand. The resolution was given to Commissioner Pawlewski the next week.
February 18, 1983	Letter of this date from Ana Warner, PPSI, stating they had voted to ask FPC of I for Title X funds.
February 23, 1983	Meeting with all Family Planning Agencies except PPSI. Commissioner Pawlewski addressed the group. He indicated his support for family planning; he also stated that he had considered his options and had chose to not transfer funds.

ATTACHMENT 2

February 25, 1983	Letter from Buzz Crowder, R.O. VII, specifying that we are able to continue service to current service area through June 30, 1985; specific contract agencies are not the issue.
February 25, 1983	Letter of this date from Melanie Bohl, PPSC, indicating they would ask FPC of I for Title X funds.
February 28, 1983	Phyllis Blood (ISDH) and Jill June spoke separately before the Executive Committee of Hillcrest's Board of Directors. Ms. Blood asked if there were specific concerns. She was told that staff had already briefed the Committee; their specific questions centered solely on whether or not Commissioner Pawlewski would transfer the dollars. The Crowder letter was shared with them.
March 1, 1983	The Iowa State Department of Health non-competitive grant for family planning funds was received by Regional Office.
March 11, 1983	Letter from Don Sanders, Hillcrest Board President, stating they were not renewing contract for FY84, and that they'd request dollars through other umbrella.
March 16, 1983	Family Planning Council of Iowa grant into Regional Office included service areas for the three agencies. R.O. Grants Management (Dean Chocholousek) rejected it as being a competitive application. It was sent back to them, with specific instructions for a non-competing application to be sent in by April 1.

ATTACHMENT 2

March 16, 1983

Iowa State Dept. of Health
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Office of Commissioner

Ms. Jill June
Executive Director
Family Planning Council of Iowa
8450 Hickman, Suite 78
Des Moines, Iowa 50322

Ref: Family Planning Continuation Application
Grant No. 07-H-000418-04

Dear Ms. June:

Returned herewith are the three copies of the above application which was received in our office this date. The application is being returned as it is unacceptable.

As you are aware, an application from your organization for the provision of Family Planning services in certain areas of Iowa was funded with a project period ending date of June 30, 1985. Therefore any application submitted during the project period is a non-competing continuation application.

The application you submitted, Ms. June, proposes an expansion of your services to areas currently served by another of our grantees. It therefore becomes a competing application (within a project period) against one that has already been submitted to us as a non-competing.

Should you desire to submit a non-competing application for the provision of services in the areas previously approved please do so at the earliest. Your current budget period ends June 30 which is only about 100 days away. Time will be consumed in revising your application, in HSA, SHPDA, and in A-95 reviews.

Frankly, Ms. June, if we do not receive your non-competing application by April 1, we cannot guarantee funding by July 1.

If we can be of any assistance to you, please contact us.

Sincerely yours,

Dean B. Chocholousek, Director
Office of Grants Management

bc: Mr. Crowder
Mr. Pawlewski

ATTACHMENT 3

ALERT FOR CHOICE

A Call to Action

Dear Pro-Choice Supporter:

Your help is critically needed to protect our fundamental right of Freedom of Choice. The Right-to-Lifers are strongly organizing for the precinct caucuses. Our goal is to ensure that the pro-choice voice is heard at every precinct caucus across the state.

It is important that pro-choice supporters from both parties attend the caucuses and support pro-choice resolutions that will eventually become part of state party platforms.

ACTION ALERT

We ask you to propose and support a pro-choice resolution at your precinct caucus.

We urge you to contact at least 5 pro-choice friends and relatives and encourage their precinct caucus attendance and participation to promote and support pro-choice.

The caucuses will take place on Monday, February 20 at 8 p.m. Check your local newspaper or call the County Auditor or party headquarters for the exact location.

Our next mailing will include a copy of the rules governing both the Democratic and Republican caucus procedures.

1984 Precinct Caucus Reproductive Rights Resolution:

We, the people of the ______ precinct, support the U.S. Supreme Court decisions which guarantee reproductive freedom and we oppose all legislation and amendments to the state or federal constitutions which would limit reproductive freedom.

ALERT!

ALERT!

Planned Parenthood
of Mid-Iowa
P.O. Box 4557 Des Moines, Iowa 50306
ADDRESS CORRECTION REQUESTED

NON-PROFIT ORG.
U.S. POSTAGE
PAID
Des Moines, Iowa
Permit No. 3108

ALERT!

ALERT!

ALERT!

ATTACHMENT 4

II.

EXPLANATION OF THE CURRENT FORMULAS

A. Introductory Comments:

Title V establishes the skeletal bases upon which the current maternal and child health and crippled children's services formulas are constructed. There is general agreement that the title has as its major objective the provision of health services to those who otherwise could not afford such services, especially those residing in rural areas. Rurality and financial need ("serve economic distress" is the term used in the initial Section 501) are generally recognized as the preponderant themes expressed by the authorization.

Before providing a technical exposition of the two formulas (MCH and CC), it may be helpful to itemize the major guidelines provided by the title. These guidelines leave determination of the elements of the precise formulas which are applied to appropriated funds to the Secretary, DHEW, and to those who have been delegated authority by him. To date the question of whether or not the detailed "applicable" and technical formulas are equitable "interpretations" of the intent of the Congress has not been answered definitively, at least in a formal sense. In a legal sense the question was answered when an Office of General Counsel authority pronounced acceptable the formulas developed by the statisticians and approved by the responsible program director.

Here are the guidelines expressed in the title regarding allocations of monies:

Allocation of Funds

For Maternal and Child Health	For Crippled Children's Services
1. An "A" fund and a "B" fund on a 50/50 ratio (Sec. 503)	1. An "A" fund and a "B" fund on a 50/50 ratio (Sec. 504)
2. $70,000 minimum to each jurisdiction under the "A" fund (Section 503 (1))	2. $70,000 minimum to each jurisdiction under the "A" fund (Sec. 504 (1))
3. State live births to national ratio in both "A" and "B" funds (Sec. 503 (1) and (2))	3. State number of crippled children to national ratio in both "A" and "B" funds (Sec. 504 (1) and (2))
4. Financial need in the "B" fund (Sec. 503 (2))	4. Financial need in the "B" fund (Sec. 504 (2))

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Personal & Family Health

5. Up to 25 percent reserve against the "B" fund for discretionary grants of regional or national significance (Sec. 503 (2))	5. Up to 25 percent reserve against the "B" fund for discretionary grants of regional or national significance (Sec. 504 (2))
6. Rural priority coupled with recognition of areas suffering from severe economic distress (Sec. 501)	6. Rural priority coupled with recognition of areas suffering from severe economic distress (Sec. 501).

B. The Formulas:

It should be noted that there exists an earmark of funds for discretionary grants for projects for the mentally retarded. This is not identified anywhere in the title but was instituted at the behest of Congress in response to the need for special programs for the mentally retarded. (See Appendix E.)

The Maternal and Child Health and Crippled Children's Formulas, Title V of the Social Security Act.

The statute divides the amount to be allotted to States into two parts; it further determines precisely how the "A" fund is calculated, and to a lesser extent, the "B" fund.

For the "A" fund, each State is allotted $70,000 by statute plus such part of the remainder as the number of live births in the State bears to the number of live births in the United States.

The formula used to calculate a State's share of the "B" fund is based on the financial need of each State for assistance in carrying out its State plan after taking into consideration the number of live births in such State. This is described in detail in the attached statement. The rurality emphasis in the purpose clause (Section 501) is taken care of by weighing rural live births by a factor of 2 to 1 urban live birth.

In the crippled children's program, the number of children under 21 is substituted for the number of live births. The process is otherwise the same.

Under Section 516 of the statute, funds are made available for Maternal and Child Health activities relative to the "Hold Harmless" provision of P.L. 93-53. These funds represent the excess of a State's total Federal funds for Maternal and Child Health, Crippled Children's Services and Programs of Projects for fiscal year 1973 over what a State would receive under the current allotment formulas for MCH and CC.

1. Basis for Allocation of Funds - Maternal and Child Health Services

One-half of the maternal and child health funds are apportioned among the States by a formula specified in the law (Section 503 (1)). These funds are referred to as "Fund A." Each State receives a grant of $70,000 and such part of the appropriation remaining as the number of live births in the State bears to the total number in the United States.

The other half of the maternal and child health grant (Section 503 (2)) is known as "Fund B." From this fund an amount designated by administrative action (formerly by the Appropriation Act) is allocated for special projects for mentally retarded children. From the remainder of Fund B, 75 percent is apportioned among the States according to the financial need of each State for assistance in carrying out its State plan. The formula for the apportionment employs the following steps:

a. Rural live births, each State[1].

b. Urban live births, each State.

c. (a) times 2 plus (b), each State.

d. (c), each State, multiplied by total live births, U.S., divided by sum of (c) for all States.

e. (a) plus (b), each State, multiplied by State percentage (one-half the ratio of State per capita income to U.S. per capita income).

f. (d) minus (e), each State.

g. (f), each State, multiplied by (total Fund A, U.S., plus Fund B to be apportioned, U.S., divided by sum of (f) for all States).

h. (g) minus Fund A, each State,

i. Trial apportionment for minimum allotment of $70,000.

   To any State for which (h) is less than $70,000, the sum of $70,000 is assigned. The sum of amounts so assigned is subtracted for the total of Fund B to be apportioned. The remainder is then distributed to other States in proportion to amounts shown in (h). If any State receives less than $70,000, succeeding trial apportionments are required until no State receives less than $70,000.

The remaining 25 percent of Fund B is reserved for special projects of regional or national significance which may contribute to the advancement of maternal and child health, and payment is made on a project basis.

Source of Data: Live births--annual reports by Division of Vital Statistics of the National Center for Health Statistics. Per capita income--Department of Commerce, averaged for the three-year period.

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[1] For the District of Columbia the first three steps do not apply. Item D for the District of Columbia is the number of live births.

Senator **Denton**. Mr. Commissioner, I note that you support the current role of the DASPA and have found the office responsive to your needs, from your point of view. And I want to make sure I have something straight. Thirty-three States now are receiving their title X funding in the way which you recommend; 10 are mixed, with Iowa being—excuse me. Go ahead, correct me.

Mr. **Pawlewski**. They are all project grants and contracts. None of the States are receiving it as a formula grant, but we are recommending that there be a formula grant. In Iowa, there are two grantees—the Family Planning Council of Iowa, which split off into my department in 1980 because of an audit dispute that we had, as well as——

Senator **Denton**. Let me get one thing straight first, though. Thirty-three States do receive this money at one place, the public health service, as it were, for the State?

Mr. **Pawlewski**. To the best of my knowledge, yes.

Senator **Denton**. And Iowa is different in that, although you would prefer something like that, you are split—would you tell us how that came about and what your experience has been regarding political and abortion-related activities by title X grantees?

Mr. **Pawlewski**. Well, we had a number of difficulties with some of our agencies, especially those who were affiliated with Planned Parenthood, adhering to the Federal regulations, especially in regard to abortion but also other regulations. And we had an audit report in, I believe it was 1979 and 1980, that indicated that there were title X funds comingled with their local funds for telephone counselors, for supplies, and other aspects of the abortion services which were offered on the same premises as their family planning services. When we tried to enforce these regulations, they mounted a campaign, a lobbying campaign, against the department and against me specifically as commissioner. They attempted to get my confirmation as commissioner denied by the Iowa Senate, by enlisting the assistance of some Senators who were proabortion, and finally, it got to the point where we requested that they leave us, that we could not effectively administer the program with integrity because they would not adhere to the regulations, and the regional office would not force them to adhere to the regulations.

Senator **Denton**. What are they doing now, outside the umbrella of your supervision?

Mr. **Pawlewski**. They have formed their own umbrella called the Family Planning Council of Iowa. We have continued to have problems with them. Last year, at the project grant time, they attempted to take three of the agencies that are presently under my administration and put them under their umbrella, which would have cut our funding down to such a level that we would have had difficulty administering the program for the other agencies that did not want to go with this other umbrella. It would have also put them in a position, I believe, a position toward which they are aiming, and that is to take over the family planning program of the State of Iowa. They would like to get the State health department out of it and administer it directly as a private, nonprofit organization because they have less oversight, and they are free to do more with the funds than they are allowed to do under our administration.

Senator DENTON. Let me see if I understand. They are no longer under the States' single source, as it were, supervision and oversight; they are separate, but they still receive Federal funds if they successfully apply as grantees. Do you have any reason to believe that they are or are not still committing the abuses which you have contended that they were doing?

Mr. PAWLEWSKI. Well, I would suggest, Senator, that if they were committing them while they were being monitored, they are probably committing them while they are not being monitored. As far as I know, they have not been audited; they have not even been visited by Federal officials who are supposed to administer that program from the regional office.

Senator DENTON. How do you determine the eligibility of minors for services under your system in Iowa? That is, do you determine it on the basis of their income level or on the income of their parents, or some other way?

Mr. PAWLEWSKI. We take into account the support—room, board, clothes, et cetera—parents provide as well as the income that the teenagers have. We combine both of them. We began this project about a year ago. A sample policy is provided with other written material submitted.

Senator DENTON. Can you think of any reason why that should not be done nationwide, and what opinion do you have of the procedure of considering only the minor's income?

Mr. PAWLEWSKI. I believe it should be done nationwide. I believe that these funds are intended more for the poor and moderate income, and that people with sufficient means of their own ought to pay for them.

Senator DENTON. In other words, it might be that some poor adult women may not be as well-served in the various ways that they could be served if we are taking care of what really amounts to wealthy or middle class young people.

Mr. PAWLEWSKI. We estimate that we are reaching approximately 50 percent of our target population of poor women, and any dollars that are diverted to inappropriate use are keeping us from reaching those women with services. One of the problems that I see in Iowa is that many of the funds are used for political lobbying purposes that could be used for services. There are also attempts by the other grantees to open duplicative services in our territories and counties that are covered by our grants, and this is a constant bickering between the two agencies.

Senator DENTON. Could you send us some examples in print of the campaign conducted against you, or other kinds of political lobbying that has been undertaken?

Mr. PAWLEWSKI. I would be happy to, Senator. I have all kinds of documentation for the things I have said here this morning.

Senator DENTON. We appreciate the fact that you were up until late last night, as was my staff, to receive your testimony. We did not prepare as many questions for that reason as we did for the administration witnesses, but I want you to know I am appreciative of your testimony, your willingness to come out here, and your serious commitment to solving this problem. And we would solicit any recommendations you might have for us when we try to draw up a reauthorization bill.

Mr. **Pawlewski**. I would be glad to do that, Senator. I am very supportive of the family planning services from a public health perspective, even though I am very adamantly opposed to any abortion services at all. I think there ought to be a very strict and clear denial of funds to any agency that provides abortion services in conjunction with family planning services. It is not a family planning methodology; it is a family planning failure.

Senator **Denton**. Thank you, Mr. Pawlewski.

I am going to ask one of the witnesses out of the sequence which we had planned, because an unforeseen requirement at home necessitates it.

I will ask Mrs. Judie Brown, the president of the American Life Lobby, to come forward.

Good morning, Mrs. Brown. I want to say again that Mrs. Brown is the president of the American Life Lobby, and I will ask if you have an opening statement. I am sorry that something has come up at home, Mrs. Brown. I hope it is not serious.

STATEMENT OF JUDIE BROWN, PRESIDENT, AMERICAN LIFE LOBBY

Mrs. **Brown**. Well, my 9-year-old daughter appreciates this much more than I, because she is very ill.

I would like to open my remarks this morning by thanking you in particular for your pursuit of the inactivity on the part of the Reagan administration with regard to GAO Reports HRD-81-68 and HRD-82-106. We are so grateful to you for pursuing those GAO reports to find out why nothing of a substantive nature has been done.

As the president of the American Life Lobby, I have pointed out in my complete statement some of the reasons why there are serious problems with title X of the Public Health Service Act. In the past, over $1.5 billion has been spent on this program. Nevertheless, illegitimacy, venereal disease, and teenage pregnancy rates have continually climbed. Between the years of 1971 and 1979, for example, the number of teenagers in federally subsidized birth control programs has increased by 397 percent. This is impressive until you discover that the number of females who use contraceptives, birth control devices, but experienced premarital, unwanted pregnancy has increased by 266.3 percent.

What is happening to these babies? Live births for these teenagers have decreased 10.5 percent. The teenage abortion rate, however, has increased 106.8 percent.

Mr. Chairman, these are not the statistics of a successful, billion-dollar program. To the contrary, they show marked and repeated failure and thereby, a total waste of Federal tax dollars.

In 1982, GAO investigations conducted at your request found that all of seven grantees investigated for this purpose had incurred lobbying expenses or expenses which raised questions as to Planned Parenthood's adherence to Federal restrictions. Two recipients cited in this report in particular were actually engaged in lobbying, while five others used program funds to pay dues to other organizations which did lobby. These dues, ranging from $25 to over $27,000, totaled $42,000.

I would like to cite for the record once again a statement that Faye Wattleton, the president of Planned Parenthood Federation of America made in writing to Charles A. Bowsher, Comptroller General of the United States, dated November 10, 1981. She said, "No Planned Parenthood affiliate or clinic promotes abortion with or without public funds."

I have here a full-page ad which the Planned Parenthood Federation of America placed in the Washington Post just a few short weeks ago. This is an obvious promotion of abortion. In addition to exhibits which I have attached to my testimony and made a part thereof, it is obvious that they are promoting abortion and lobbying against pending legislation to ban abortion.

The National Family Planning and Reproductive Health Agency News, on December 10, 1982, page 11, the monthly newspaper of that organization, stated: "Of the title X clinic sites operating in 1981, 21 operated by the Planned Parenthood affiliates provided abortion."

Although this is not totally inconsistent with Mrs. Wattleton's letter to Comptroller General Bowsher, which says in part that "the 37 Planned Parenthood affiliates that provide abortion do so with private revenues and State public funds," it gives a very different view than that given by NFPRHA News.

Our organization, the American Life Lobby, did a survey inhouse of all Planned Parenthood affiliates. Fifty-point-eight percent of their affiliates responded to this survey. Of those 46 percent said that they counseled minor children in favor of abortion without parental consent, or counseled for abortion as an alternative method of birth control. Forty-one percent of these respondents said that they referred minor children for abortions without parental consent.

Mr. Chairman, if this is not a promotion of abortion, I do not know what is.

We have made several recommendations to the administration which I would like to make to you again with regard to title X and the Public Health Service reauthorization. Our primary goal, of course, would be to see this program totally unauthorized, but we realize that that is probably politically impossible. Therefore, we would recommend that: any proposed reauthorization of this program should be for no longer than a 1-year period of time; that the appropriation should be reduced, and the reauthorization itself requesting these funds reduced by a minimum of $48 million, which is the exact amount cited by GAO as money that has been spent for waste, fraud, and abuse, as cited by the GAO in their report; that Section 1008 of the current title X law should be rewritten, as suggested, to prohibit any funds from being used to perform abortion, abortion-related services or lobbying, particularly in favor of proabortion legislation.

I realize that I am out of time, Mr. Chairman and I thank you for your consideration of my testimony.

[The prepared statement of Mrs. Brown follows:]

TESTIMONY OF MRS. JUDIE BROWN

PRESIDENT, AMERICAN LIFE LOBBY

AGAINST REAUTHORIZATION OF TITLE X OF THE PUBLIC HEALTH SERVICE ACT BEFORE THE SENATE SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES

APRIL 5, 1984

Mr. Chairman, members of the committee, I am Mrs. Judie Brown, President of the American Life Lobby, the largest pro-life, pro-family organization in the country, with over 135,000 members. I would like to speak to you today about eliminating, or at least cutting the funding for Title X of the Public Health Service Act which expires on September 30, 1984.

In the past, over 1.5 billion dollars has been spent on this program. Nevertheless, illegitimacy, V.D. and teenage pregnancy rates have continually climbed.

For example, since 1971,* the number of teenagers in federally subsidized birth control programs has increased 397%. This is impressive until you discover that the number of females who use contraceptives but experienced pre-marital, unwanted pregnancy has increased by 266.3%.

What happens to these babies? Well, live births for these teenagers have decreased 10.5%, while the teenage abortion rate has increased 106.8%.

As for venereal disease, it appears that our federal dollars have had no effect since 1971,* with a marked increase in V.D. for women between the ages of 15 and 19, of 92.8%.

Mr. Chairman, these are not the statistics of a successful, billion - dollar program. To the contrary, they show marked and repeated failure and thereby, a total waste of federal tax dollars.

In September 1982, the General Accounting Office issued a highly critical report of this waste and abuse as well as other questionable activities carried on with our Title X funds.

First, I call your attention to section 1008 of Title X, which reads, "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning", and the explanation offered by Congressman Dingell on November 16, 1970, 116 Congressional Record 37375:

> The committee members clearly intend that abortion not to be encouraged or promoted in any way through legislation. Programs which include abortion as a method of family planning are not eligible for funds allocated through this act.

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*1971 to 1979

The Department of Health and Human Services has, according to Inspector General Richard P. Kusserow, on July 3, 1983, interpreted section 1008 as requiring "that federal funds not be used to finance abortions, and that the discrete project in which Title X funds are spent not include any activities which promote or encourage abortions."

In addition, the Hyde amendment, has since 1977, prohibited the use of funds appropriated to the Department of Health and Human Services to pay for abortions, except in certain limited circumstances.

Nevertheless, at least one organization funded by this program has consistently and blatantly violated at least the spirit and intent of section 1008 [and the intent of Congress]. I speak of the Planned Parenthood Federation of America and/or its affiliates.

Not only did their affiliate in Metropolitan Washington, D. C., apparently use Title X monies to sponsor National Condom Week and the "Rubber Disco" and expend funds for a full page in the Washington Post, asking individuals to oppose any restrictions on abortion, but they had continually violated the lobbying and advocacy prohibitions contained in several appropriations acts. These prohibitions provide that no appropriated funds shall be used by grantees to influence legislation pending before Congress.

In an effort to statutorily prohibit these activities, I have proposed to the Administration, and now to you, the following clarifying language:

> None of the funds authorized under this title shall be used in programs or in referrals to programs or in counselling as to programs where abortion is a method of family planning.

The Administration has not acted on this matter, other than proposing (as they have done for the last three years to no avail) a spurious "block grant" alternative.

Mr. Chairman, a "block grant" is simply not good enough. Something must be done to curb the abuse of taxpayers'funds, and it is up to you and your committee to act now.

A 1982 GAO investigation conducted at your request found that all of seven grantees investigated for this purpose, ah had incurred lobbying expenses or expenses which raised questions as to Planned Parenthood's adherence to federal restrictions. Two recipients were actually engaged in lobbying, while five others used program funds to pay dues to other organizations which lobbied. These dues, ranging from $25.00 to over $27,000.00, totaled $42,000.00.

Specifically, and in pertinent part, GAO found:

At the Federal level:

--Two recipients spent program funds for transportation, lodging, and other expenses associated with attending conferences in Washington, D. C., during which officials visited Members of Congress and/or their staff and lobbied against pending legislation to incorporate Title X into a block grant. About $200 was spent for the activity.

--One recipient incurred undetermined costs associated with writing the Congress to lobby against pending legislation. The costs involved salaries and expenses related to preparing and distributing the correspondence.

--One recipient displayed a poster and distributed postcards at a Title X clinic encouraging clients to write their congressional representatives to urge them to vote "pro-choice" on pending legislation. Costs associated with this activity were too obscure to calculate. However, HHS holds that Title X recipients are not to advocate abortions or even foster a favorable attitude toward abortions.

At the State level:

--One recipient incurred costs for attending a conference that involved lobbying at the State level. About $113 was spent on this activity.

--One recipient provided space for about six weeks in a Title X clinic to an organization involved in lobbying at the State level and, as a result, program funds were indirectly involved.

GAO concludes, as do we, that "clear federal guidance is needed both to insure that Title X program funds are not used for lobbying and to preclude unnecessary controversy over whether grantees are violating federal restrictions." Mr. Chairman, you requested this report. It is your committee's responsibility to address the deficiencies and improper behavior identified by GAO, with remedial legislative restrictions.

No one can deny, especially in light of the GAO report, that their advocacy and lobbying are being subsidized by the American taxpayer. Their lobbying and advocacy and their government grants are inexoriably intertwined.

You may recall that during the 97th Congress' debate over Title X, Planned Parenthood spearheaded grassroots and public relations lobbying against changes in Title X regulations that would require parental notification. HHS reportedly received over 100,000 postcards and letters, many against the notification rule.

Mr. Chairman, as you are acutely aware, prescription contraceptives such as the pill or IUD can have serious health side effects. Researchers are continually discovering new information on these health risks. For example, a recent study at the Johns Hopkins School of Medicine, reported in the Journal of the American Medical Association, on August 12, 1983, revealed that the IUD can cause serious health problems for high school and college-aged women who have never had children.

Given this risk, parental consent is certainly the least intrusive method, insuring minimal protection of unemancipated teenagers, age 12 to 17. If the Title X statute is amended to require all grantees to obtain prior parental consent, it will solve the problem that now exists in the state of Utah, which now has such a parental consent law.

Should this committee include parental consent in any reauthorization of Title X, as we sincerely hope you will, it would send a message to the American family that Congress is concerned about the family unit and believes that it should be involved in the decision of a young person to submit herself to drugs or devices which may possibly harm her body. The ability of parents to help to foster the development of their children is an important one, and one which the government should not interfere with.

Yet, it was this very relationship that Planned Parenthood became so enraged about, that it, contrary to statutory prohibitions, organized a major lobbying effort against the Administration's weaker, after-the-fact, notification proposal. How many of the 100,000 postcards and letters received at HHS were generated at federal, taxpayer-financed clinics by federal taxpayer-financed workers and mailed to HHS with federal taxpayer financed postage or postage meter?

Mr. Chairman, the need for tighter regulations is unquestioned - - GAO said so. The National Family Planning and Reproductive Health Association in its December 10, 1982, NFPRHA News, stated that among 74 Title X grantees, there were 21 Planned Parenthood affiliates that performed abortions on site with the Title X clinics. Planned Parenthood of Southeast Pennsylvania, in the now-famous ERA case, self-identified themselves as operators of an abortion clinic performing 2,000 abortions per year.

Planned Parenthood of Missouri was identified by the Chief Judge of the U. S. Eighth Circuit Court of Appeals in a July 8, 1981, decision, as one of two "corporations that operate abortion clinics".

The Pennsylvania Planned Parenthood Affiliate received $655,416.00 in 1980 and $616,061.00 in 1981 from Title X. The affiliates in Kansas City, Missouri, received $276,196.00 in 1980 and $295,272.00 in 1981 from Title X.

Advocacy is so intertwined with federal program dollars that tough restrictions must be added to Title X itself to solve the complex, intermingling of program funds and advocacy. And what of abortion, already prohibited in most instances by the Hyde Amendment?

In a letter to Charles A. Bowsher, Comptroller General of the United States, dated November 10, 1981, Faye Wattleton, President of Planned Parenthood Federation of America, complained of too many audits and the manner in which they were conducted. She stated, "No Planned Parenthood affiliate or clinic promotes abortion with or without public funds."

Mr. Chairman, that statement to Mr. Bowsher is just not accurate, for three reasons:

1. From the two exhibits attached hereto and made a part hereof, it is obvious that they are promoting abortion and lobbying against pending legislation to ban abortion.

2. NFPRHA NEWS, December 10, 1982, page 11, the monthly newsletter of the National Family Planning and Reproductive Health Association, Inc., states, "Of the Title X clinic sites operating in 1981...21...operated by Planned Parenthood affiliates...provided abortion." Although this is not totally inconsistent with Mrs. Wattleton's letter to Comptroller General Bowsher, which says in part that "the thirty-seven Planned Parenthood affiliates that provide abortions do so with private revenues and state public funds...," it does give a very different view than given by NFPRA NEWS.

3. My organization did a telephone survey of all Planned Parenthood affiliates to which 50.8% responded. Of those, 46% said they counselled minor children in favor of abortion without parental consent or counselled for abortion as an alternative. Forty-one percent of the respondents said that they referred minor children for abortion without parental consent [All About Issues, September, 1982, page 44].

Mr. Chairman, if that isn't promotion of abortion, I don't know what is. Abortion promotion and counselling is advocacy, and as you, your colleagues and unborn babies know, abortion is painful as a procedure and is terminal for at least one of the patients.

It is wrong to require the taxpayers to fund this and any other form of advocacy.

I believe that if the following language was added to the reauthorization bill, it would greatly deter such abuse:

> (b)(1) None of the funds authorized to be appropriated under this title shall, in the absence of express authorization by Congress, be used directly or indirectly to pay for any personal service, advertisement, telegram, telephone, letter, printed or written matter, or other device, intended or designed to influence in any manner a Member of Congress to favor or oppose, by vote or otherwise, any legislation or appropriation by Congress, whether before or after

> the introduction of any bill or resolution proposing such legislation or appropriation; but this shall not prevent officers or employees of the United States or of its departments or agencies from communicating to Members of Congress on the request of any Member or to Congress, through the proper official channels, requests for legislation or appropriations which they deem necessary for the efficient conduct of the public business.
>
> (2) None of the funds authorized to be appropriated under this title shall, in the absence of express authorization by Congress, be used directly or indirectly to pay for any personal service, advertisement, telegram, telephone, letter, printed or written matter, or other device, intended or designed to influence in any manner a member of a state or local legislative body or executive agency, to favor or oppose, by vote or otherwise, any legislation or appropriation by such legislative body or executive agency, whether before or after the introduction of any bill or resolution proposing such legislation or appropriation; but this shall not prevent officers or employees of the state or local government or of its departments or agencies from communicating to a member of a state or local legislative body or executive agency on the request of any member of a state or local legislative body or executive agency, through the proper official channels, requests for legislation or appropriations which they deem necessary for the efficient conduct of the public business.

Mr. Chairman, the American Life Lobby would ,of course, like to see no funding for Title X. However, we recognize that however justified, a "zeroing out" of this program would not be in the realm of political possibility.

Therefore, we reluctantly but very firmly request that the committee at least clean up the Title X program by doing ,at a minimum, the following four things:

1. Any proposed reauthorization should be for one year, FY 1985 only.
2. That appropriation should be reduced by $48 million, which is completely justified by reduction of the waste and duplication of services documented and recommended in GAO Reports, HRD-81-068 and HRD-82-106.
3. Section 1008 of the current Title X law should be rewritten as suggested to prohibit any funds from being used to perform abortions, abortion-related services or lobbying, particularly in favor of pro-abortion legislation.
4. A programatic audit should be conducted by the GAO to determine the program's effectiveness and realization of the goals outlined at the program's inception, with the purpose of ascertaining whether the program is cost-effective and worth salvaging.

These proposals, if adopted, will save money that is now being wasted, and get the government out of the abortion advocacy business, at least in part.

Thank you for your time.

Senator DENTON. Thank you, Mrs Brown, and I will ask you but two questions and proceed to the next witness, in view of your and their shortage of time.

Mrs. Brown, supposing for a moment that the changes you have suggested are made in the title X program—that is, that we clearly separate abortion-related activities from the provision of title X services, and deal with the question of services to adolescents in the manner in which you would like to see done.

Do you see any ways in which the members of the prolife community could participate in the provision of information and services to low-income women?

Mrs. BROWN. I think that we have to separate, as Senator Helms recommended, the married couple, poverty-stricken and in need of assistance, from all other individuals who are now seeking and receiving the assistance of my taxpayer money for birth control methods, in particular, unemancipated minor children. These children are the primary responsibility of their parents. I have teenagers of my own. I do not want the Federal Government entering into their private lives and advising them on matters of their human sexuality. That is a matter for parents to discuss with their children. Mr. Chairman, I do not feel that the Federal Government's place is in the provision of birth control devices in any way, shape, or form with unemancipated minor children.

Senator DENTON. Mrs. Brown, have you participated or been asked to participate in any advisory councils that the Office of Family Planning has created?

Mrs. BROWN. No, Mr. Chairman, we have not.

Senator DENTON. And lastly, has the Office of Family Planning been responsive to your requests for information about the operation of the family planning program?

Mrs. BROWN. The last response that I received was 13 months late, but I did receive it. Some of the requests that we have made have never been answered.

Senator DENTON. Thank you very much, Mrs. Brown, and I hope your 9-year-old gets better.

Mrs. BROWN. Thank you, Mr. Chairman.

Senator DENTON. We would ask Dr. Hanna Klaus, whose time is also very short. We also have Dr. Breen, whose time is running short, and I want to acknowledge that we are attempting to expedite the hearing.

Dr. Hanna Klaus is the executive director of the Natural Family Planning Center for Washington, DC., and I am looking forward to hearing your testimony, Dr. Klaus. Would you please feel free to begin?

STATEMENT OF HANNA KLAUS, M.D., EXECUTIVE DIRECTOR, NATURAL FAMILY PLANNING CENTER FOR WASHINGTON, DC

Dr. KLAUS. Thank you very much, Senator, for the opportunity of speaking.

I am a gynecologist. I have worked for 11 years in natural planning research and program planning, and 3 years' experience with adolescent fertility awareness.

I would like to speak to the following areas, which I believe impact on the reauthorization of title X.

No. 1, service provision of natural family planning.

Natural family planning is planning to achieve or avoid pregnancy by the timing of intercourse. Its reliability has been amply proven. When NFP was inserted into title X, the utility of the modern methods was not accepted by family planning providers in general. As late as 1980, 90 percent of NFP services were provided by the private sector.

Worldwide, method failure rates of modern NFP methods range from 0 to 2.8 percent, while informed choice pregnancies vary with the motivation of the user, 0.3 to 6 percent in India, over 23 percent in Latin America. In the United States, the use of natural family planning by currently married women rose from 2.8 percent in 1973 to 4.7 percent in 1982——

Senator DENTON. Would you repeat that, please?

Dr. KLAUS. It went from 2.8 in 1973 to 4.7 in 1982. This is from the National Survey of Family Growth, Cycle 3.

Yet half the GYN texts published in the last 2 years do not even mention natural family planning.

While public sector provider NFP clinics usually have a separate site for NFP services, staffed by natural family planning teachers recruited from the private sector, referrals from multimethod private clinics who receive title X funds vary widely and are often only made if the client insists. Most adolescent clinics do not even consider teaching NFP to their clients.

The regulations of DHEW in the implementation of title X have provided problems of conscience for private sector providers by demanding a commitment of client referrals for artificial contraceptives and sterilizations "if the client requires them." These regulations have been counterproductive as the private sector agencies who serve the poor precisely in terms of their institutional philosophy have contributed the most services and received the least funding for natural family planning. Quality service with adequate followup is essential for proper learning of natural family planning.

I respectfully recommend that if title X is reauthorized that NFP be offered with scientific integrity, that the freedom of conscience of those providers who are unable to refer clients for sterilizations or artificial contraceptives be respected, and that adequate compensation for services be provided.

On the topic of parental involvement in family planning, our pilot study, detailed in the testimony, shows that obtaining parental consent prior to providing fertility awareness/natural family planning to adolescent girls neither undermines the program, nor does it produce an increase in sexual activity or teen pregnancy.

In our study group, 10 percent were sexually active at entry, this number reduced to 5 percent by the end of the study; there was one informed choice pregnancy, with a rate of 5.1 per 1,000 women-years. There were also two pregnancies among the dropouts, which would give a rate of 10, which is still considerably lower than the rate for other teen studies. We attribute the difference to the fact that we place a high, rather than a nonvalue on the possession of procreative capacity, and that we use an educational approach which allows for integration of the knowledge of cyclic fertility with ongoing discovery in the girl's life.

As regard low-income and minority groups, NFP has been welcomed where it has been available and used successfully. There was concern that some family planners make untested assumptions that NFP will not be acceptable or used properly by the poor, and by curtailing the options, clients have often been pushed into sterilization. When sterilization is elected in the absence of full knowledge of other options, informed consent is lacking. Data are cited to show that this may be widespread.

Considering the high human and monetary costs of sterilization, one questions why a normal state—fertility—requires surgical ablation, especially when harmless, reliable, and reversible methods are available.

Finally, I would like to summarize that in infertility counseling, the ordinary instruction in the cyclic pattern of mucus is seldom given to people before one jumps to expensive, invasive, and risky studies. I think professional updating is in order.

Thank you very much.

[The prepared statement of Dr. Klaus and responses to questions submitted by Senator Denton follows:]

Klaus, H.

Testimony presented to Subcommittee on Family and Human Services, Committee on Labor and Human Resources, U.S. Senate

Hearing on the Reauthorization of Title X of the Public Health Service Act, Population Research and Voluntary Family Planning Programs: An Overview. April 5, 1984

Senator Denton and Members of the Subcommittee:

As a gynecologist with eleven years' experience in Natural family planning research and program planning, and three years' experience with adolescent fertility awareness, permit me to address the following areas which impact the reauthorization of Title X.

1. Service provision of Natural Family Planning. As you know, NFP is planning to achieve or avoid pregnancy by the timing of intercourse. The timing of intercourse depends on the recognition of the fertile phase. The primary prospective marker of the fertile phase is the cervical mucus which is utilized by itself in the Billings method, or in tandem with the thermal shift (symptothermal method.) Procreative choice can be achieved reliably with either method.[1]

When natural family planning was inserted into Title X, the utility of modern NFP methods was not yet accepted by family planning providers in general. As late as 1980, 90% of NFP in the U.S. was provided by over 1500 private sector teachers. Those Title X clinics which provided NFP usually did so by offering NFP in a separate site with teachers and program directors recruited from private sector.[2] Public sector addressed NFP only in terms of pregnancy avoidance. In 1981 Population Reports[3], while acknowledging the new use effectiveness designations provided by NFP physicians[4] still clung to the belief that every pregnancy incurred during NFP use was a failure, even though the division between method and user failure was gaining recognition. The 1983 WHO report[5] recognized the NFP physicians' categories, even though still operating out of a contraceptive frame, calling informed choice pregnancies "conscious departure from the rules of the method." They reported that 93% of 869 women in four continents reported an interpretable pattern of the cervical mucus their first cycle.

Worldwide the method failure rates of modern NFP methods range from 0 - 2.8%, while informed choice pregnancies vary with the motivation of the user- 0.3 - 6% in India, over 23% in Latin America. In the U.S. the use of natural family planning for pregnancy avoidance among currently married women rose from 2.8% in 1973 to 4.7% in 1982[6],yet barely half of the textbooks of obstetrics and gynecology published in 1982 and 1983 even mentioned contemporary NFP. With one exception,(Jones and Jones) the texts referred to natural methods as ineffective or traditional, as opposed to modern and effective methods. When NFP is offered in a condescending or inaccurate fashion, or not offered at all, the informed choice predicated for the voluntary acceptance of family planning methods in Sec. 1001.[300] (a) is effectively destroyed. While public sector family planning clinics have utilized referral to NFP clinics fairly widely, referrals from private agencies who receive Title X funds have varied widely, and were often made only in response to persistent demands from the client, rather than being a choice offered by the health care provider. The decision not to offer NFP is widespread in adolescent programs, where the providers, who receive Title X funds, refuse to offer it on the grounds that their clients will not be responsible in their use of the method-an untested assumption, which is refuted by your own clinical experience, to be discussed under adolescent programs.

In the implementation of Title X the Department of Health and Human Services has written regulations which have produced problems of conscience for private sector providers by enjoining an antecedent promise of referral for artificial contraceptive or sterilization services, "if the client wishes them." (in point of fact, it is quite difficult to find an NFP provider, and the client who succeeds in reaching her/him is quite intent on learning NFP.) Yet even a written statement from the client assuring the Regional Family Planning agency that the client only wished natural family planning methods has not always sufficed. These regulations have been counterproductive as the private sector agencies who serve the poor precisely in terms of their institutional philosophy have contributed the most services and received the least funding for NFP. Quality service, with adequate followup is essential in teaching clients NFP; repeated contacts are a requisite for learning to recognize the physiological marker(s) of the cycle, and learning to live in terms of that knowledge-in other words, to achieve autonomy. Regular program evaluation is also a requirement. While NFP does not sell a product which brings a profit to a manufacturer, it is an educational process which cannot be provided without funds.

I respectfully recommend that if Title X is reauthorized that natural family planning be offered with scientific integrity, that the freedom of conscience of those providers who are unable to refer clients for sterilizations or artificial contraceptives be respected, and that adequate compensation for services be provided.

2. Parental involvement in family planning for teens.

Our group has offered instruction in fertility awareness/natural family planning in a pilot project with 200 girls aged 15 - 17. Their parents received an overview of the program and contersigned the girls' informed consent form. While confidentiality of the girls' communications was assured, the parents were aware of the instructions and used the occasion to share their expectations and values regarding their daughters' sexual behavior. While 10% of the study group were sexually active at entry, the number reduced to 5% at the end of 12 - 18 months. There was one informed choice pregnancy, a rate of 5.1/1000 women years. Two pregnancies were reported by girls who had dropped out of the program 3 and 5 months prior to conception. If one wishes to consider these under extended use effectiveness, the rate is 10.3/1000 women years-these rates are considerably lower than those of Zelnick and Kantner[7] who report pregnancy rates of 30/1000 women years for 15 year old girls, and 22/1000 wm.yrs for age 17. Clearly obtaining parental consent was not a cause of increased teen pregnancy. The fact that the rate of sexual activity was lower than the rate of Zelnick and Kantner-22.5% at age 15, 48.5% at age 17, and that the rate reduced rather than increased may be due to the educational approach of our program. Natural family planning assigns a high value to possession of procreative capacity, unlike contraception which seeks to isolate the power to have a child out of the body of one or the other sexual partner. While both strive toward the same goal-procreative choice-the values of the approaches are radically different.

We were aware of the differences in values when we began our research. It was obvious that teen pregnancies had not decreased, had in fact, increased despite massive infusion of family planning funds. It appeared that one reason might be that the pivotal psychological task of adolescence is to integrate the now-present procreative capacity into one's gender identity. Contraception goes completely counter to the developmental thrust by isolating that which defines one as a man or as a woman out of the personality, while the youngster is of course trying to integrate this very quality as a way of growing up. The lack of appeal of the contraceptive programs may well be explained by the above. If youngsters are not offered the choice, and told, additionally, that while abstinence is desirable, "if you'e going to have sex, be sure and use something" the expectation that the youngster will be sexually active is clearly communicated. Our program monitored psychological parameters to verify our assumptions. The results are not yet complete. The program differed from other fertility awarenes programs available because it not only gave information but joined experience to theory. Only then did the girls begin to understand that they had a fertility pattern, that it was cyclic, and that they could easily recognize when they ovulated, and when they did not.

Based on our experience, offering fertility awareness/natural family planning with prior parental invovlvement has not led to an increase in sexual activity or teen pregnancy.

3. When Natural Family Planning instruction has been available to low income families there has been an encouraging response. The Title X N.F.P. program in Corpus Christi, Texas has met with excellent acceptance, limited only by the number of Spanish speaking teachers available in the Valley. Many Church-based programs offer NFP classes in the inner cities, where the response is steady. In Washington D.C., we have our first black Muslim teacher who draws her students from her coreligionists. A similar program operates in Memphis TN. NFP Services for low income families are often curtailed by providers who assume that their clients either would not be able, or would not wish to practice

periodic abstinence. At best this is making an untested assumption, at worst it is elitism. Or it may reflect the sexual mores of the provider. In any event, not offering realistic information about the effectiveness and availability and contemporary NFP deprives the client of exercising freedom of choice in deciding on their method of family planning. When the choice is limited to methods which are not acceptable for personal reasons, compliance is apt to be poor. One then sees strongly offered sterilization services, which are too often accepted because the alternatives were not honestly presented. In a survey we performed in 1980 we found that only 20% of women who either had been sterilized, or whose partners had been sterilized, had ever heard of NFP[8]. Three fourths of the women interviewed said they would seriously have considered trying NFP had they known of this option, before resorting to surgical sterilization. Clearly, their consent had not been fully informed. It is also known that even when couples think that they have completed their families, they not infrequently change their minds. In our study 41% of couples who entered our program with the intention of having no more children changed to either "spacing" or "planning pregnancy" status within 24 months.[9] The human costs of sterilizations are high. Regrets are common, and despite medical discouragement lead to attempts at reversal in perhaps 2% of the cases. Only those likely to succeed are selected for surgery, a very expensive operation requiring microsurgery, with at best an 80% expectation of success--and then perhaps one out of four pregnancies will be tubal, requiring further surgery and perhaps the permanent loss of fertility. Is it not time to question the wisdom of performing operations for the removal of normal function from a healthy body, rather than the normal rationale for surgery which is to restore health to a sick one? One cannot help but wonder about the cost of fertility manipulation, and its necessity-given the fact of reliable, harmless and reversible non medical alternatives.

4. Infertility counselling. Natural family planning can be used to achieve as well as avoid pregnancy. Conception is only possible during the days of the changing cervical mucus pattern and on the three days following the day of the "peak" mucus. Teaching couples to find their mucus pattern is an effective,inexpensive and reliable approach to the initial assessment of a couple who have difficulty achieving pregnancy. The probability of achieving pregnancy on any of the mucus days as well as the three days of probably fertility after the so-called "peak" mucus has been documented by Barrett and Marshall[10] and recently reconfirmed by W.H.O..[5] These, as well as our own studies[9] have indicate that 67 to 74% of couples who do not have pathology can achieve pregnancy by using the days of maximum fertility, yet most practitioners only use the retrospective thermal shift as part of the basic infertility workup before proceeding to expensive and invasive procedures. Once again there is unnecessary human and financial cost. I urge you to require that ordinary, inexpensive and noninvasive approaches must be given a reasonable trial before invasive and expenses methods are used. While this is ordinary common sense and good practice, the "high tech"climate of today sadly makes such a suggestion necessary.

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April 30, 1984

Senator Jeremiah Denton, Chairman
Subcommittee for Family and Human Services
U.S. Senate

Dear Senator Denton:

You were kind enough to invite me to provide you with an acceptable version of a CONSCIENCE CLAUSE which would make the Act acceptable to those who now find it unacceptable for reasons of conscience. Allow me to supply you with a suggestion for a new REFERRAL CLAUSE for Title X -POPULATION RESEARCH AND FAMILY PLANNING PRO-GRAMS, to be added to:

Sec. 1001, or Sec. 1007. or to appear as a separate Natural Family Planning Section.

NOTWITHSTANDING ANY OTHER PROVISION OF LAW, NO NONPROFIT, PRIVATE ENTITY WHICH OFFERS NATURAL FAMILY PLANNING METHODS SHALL BE REQUIRED, AS A CONDITION OF PARTICIPATION IN A GRANT OR CONTRACT UNDER THIS TITLE, TO REFER ANY INDIVIDUAL FOR DRUGS, DEVICES, STERILIZATION OR ABORTION AS A METHOD OF FAMILY PLANNING, OR TO ENTITIES WHICH PROVIDE SUCH FAMILY PLANNING SERVICES; PROVIDED, HOWEVER, THAT SUCH NATURAL FAMILY PLANNING PROVIDERS INFORM EACH INDIVIDUAL SEEKING SERVICES THAT IT PROVIDES ONLY NATURAL FAMILY PLANNING SERVICES AND NOT ALL METHODS OF FAMILY PLANNING.

Background information, as well as the answers to your two questions have been sent under separate cover.

I hope you will be able to use my suggestion. It will enable those who seek the common goal of responsible parenthood to approach it in ways consistent with their ethical value systems.

Thank you very much.

Hanna Klaus

Hanna Klaus M.D.
Executive Director

Local Secretariat of WOOMB International, World Organization/Ovulation Method/Billings

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April 30, 1984

Hon. Jeremiah Denton
Chairman, U.S.Senate Subcommittee on Family and Human Services
Hart Office Bldg. # 440
Washington D.C.

Attention Ronald M. Hunt, Staff Assistant

Dear Senator Denton:

Thank you for the privilege of testifying during the hearings you conducted on the Reauthorization of Title X of the Public Health service Act. I am returning the transcript of my testimony with corrections, as requested, the answers to the questions which you and your staff addressed to me, as well as copies of the BCHS Regional Memorandum 79-12, Natural Family Planning Services, and DHHS Pulbication No. (HSA) 80-5621.

I hope you will find the replies helpful, and will be happy to elaborate if there is need. I would be grateful if you would let me know the outcome of your deliberations.

Thank you.

Sincerely,

Hanna Klaus

Hanna Klaus M.D.,F.A.C.O.G.
Executive Director

Local Secretariat of WOOMB International, World Organization/Ovulation Method/Billings

Hanna Klaus M.D.

1. It is difficult to state why there is a prevailing notion that low-income families cannot learn to use natural family planning as effectively as other groups, since the data support the opposite conclusion. To my personal knowledge NFP subgrantees of Title X clinics in Washington D.C., and Corpus Christi, Texas, find that their low income clients do very well with NFP.

The majority of family planning providers in public, and more particularly private sector apparently assume that "those people" will not be educated or motivated enough to either learn their fertility pattern(s) nor consider them in deciding whether to have intercourse on a given day, i.e. the provider expects, fears or assumes that intercourse will be engaged in impulsively, regardless of whether the couple is fertile or infertile, even if they do not, or, in the provider's mind should not, wish to become pregnant. In the language of family planners "unprotected intercourse" is synonymous with "irresponsible intercourse." The poor are considered to be irresponsible because they have children for whose support they require public assistance.

Most physicians know that the reasons for having a baby are far more profound and complex than whether or not one can support the child. I am not advocating conceiving children when there is no forseeable way of meeting one's parental responsibilities, but the current cost-benefit approach to reducing the birth rate among the poor as a way of reducing the welfare rolls is not only degrading, but counter-productive. For instance, in the District of Columbia the number of induced abortions equals the number of live births. The vast majority of these abortions are performed on adolescents. Yet an inordinately large number of girls who are persuaded either by their health care providers, families or the welfare system that they should abort their babies, since they will not be able to support them, become pregnant within 3 - 4 months, so that in effect the medical bill for one client year includes one induced abortion, as well as the cost of prenatal, intrapartum and postpartum care. Hardly a saving of money!) When I attempted to introduce natural family planning into two areas of teen ob/gyn care in the District, the people in charge of the clinic would not consider offering it as they "already knew" the girls would not be consistent in their use of the method. This "knowledge" must have been obtained by direct infusion, since there was no experience to support it. Since NFP requires active coooperation of the client, as well as learning time, it is more time consuming than the insertion of an IUD, or the writing of a prescription. I suspect the resistance of the majority of family planning providers to NFP is based on grounds composed of economics, perceived lack of time, resistence to learning new methods, when all of one's routines have been established, elitism and ignorance.

Your question, "isn't this paternalistic" must be answered in the affirmative, and I have tried to illustrate my reasons. Abuses of civil rights of poor minority women were blatant enough to evoke stringent federal guidelines for sterilization. (Program Guidelines for Project Grants for Family Planning Services, 1981, 8.4 and Attachment C.) The history of the substitution of Society for the patient in the fiduciary doctor-patient relationship begins in paternalism but ends in gross violations of persons. The consequences of such a substitution have already been seen in the Third Reich, when all manner of defective and "unproductive" persons were sterilized for the benefit of the state, and not because they desired it.

Since natural family planning is less expensive, requires no (or few supplies, a chart, a piece of paper and sometimes a thermometer for those who prefer the symptothermal method) and keeps control of procreative choice in the hands of the couple, it makes abundant good sense to offer it to persons of low (as well as high) income.

Quite often the "poor compliance" with contraception cited by family planners as their reason for not offering NFP to the poor is in fact their rejection of contraception. Quite often clients who reject contraception willingly accept natural methods of family planning. (See #3, below.) When the only means effectively offered to clients are means which are in conflict with their value system, whether the value system is based on religion or simply their own perception that there is something wrong with a woman , or a man, who has lost her/his procreative capacity, their compliance with contraception is going to be poor. Our health care system has then moved in to make sure that these people don't reproduce by offering very few choices other than sterilization as the only "effective alternative." (Please refer to my written testimony.)

2. Many hospitals and health centers in the U.S. are operated by members of Catholic religious orders which were founded precisely

to offer free or low cost, but high quality care to those who could not otherwise afford it. The motive for offering this care was love, based on religious principles which also embraced the personal vow of poverty of the religious who provided the care.. These groups desire to serve all the health care needs of their clients, which of course include the need to help people achieve procreative choice. The manner in which this is achieved must be consonant with the ethical position of the provider, as well as acceptable to the recipient. This will be elaborated in my suggestion for a replacement of the current regulations on referral. See below.

3. You have invited me to submit my version of a "CONSCIENCE CLAUSE" for your consideration.

The entire body of Regulations for Title X was written by a Task Force of the American College of Obstetricians and Gynecologists (A.C.O.G.), whose history reflects a purely technological approach to fertility control either by reversible (medical) or permanent (surgical) means and in the language of the regulations, and in practice equates family planning with contraception. Contraception is the removal of the procreative capacity from the body of one or the other sexual partner to enable the couple to have intercourse while avoiding the (normal) outcome of intercourse during the fertile phase of the couple, namely conception. A.C.O.G.has accepted contemporary NFP very slowly and reluctantly. The progression of its patient instruc-tions on NFP from condescending and fearful to cautious, mistrusting and not yet fully accepting, can be documented from my files.

While DHHS had defined NFP as "planning for achieving or preventing pregnancy by the timing of intercourse...if the couple wishes to achieve pregnancy, they can be aware of the best days for this to occur. If the couple wishes to avoid pregnancy, they should abstain from intercourse or genital contact during the fertile or risk period. Natural family planning for preventing a pregnancy is also referred to as periodic abstinence." (*Natural Family Planning* U.S. DHHS, PHS, HSA, BCHS Publ. No. (HSA) 80-5621) and the BCHS Regional memorandum, 79 - 12, attached) the ACOG produced Regulations (8.4) destroy the distinction between periodic abstinence methods and the use of barrier methods, advising that " fertility awareness methods *including natural family planning* all come under the heading of temporary contraception, and that" more than one method of contraception can be used if the client requests it e.g. the use of 2 barrier methods, a barrier with an IUD, or the *combination of a barrier with techniques of ovulation detection*. While the physical possibility of the use of combinations is indisputable, designating such combinations as natural family planning is destructive for the following reasons:

1. It violates the definition of NFP and offends the consciences of acceptors and providers who have ethical objections to the use of contraception, because contraception presupposes an attitude toward sexuality and marriage which they find unacceptable. There is no objection to family planning as such, but to a particular form, as stated at the beginning of # 3.
2. Providers in multi-method clinics not only teach NFP

intrinsically in combination with barriers, but, in my eductional sessions have demanded that "alternative methods" of genital expression be offered and taught. To many these come under the heading of perversion, and are ethically objectionable. The psychological base for the need to offer "alternative methods" was spelled out for me by a private sector family planning educator in West Texas. "You gotta give the kids something. When they're hot, they're hot." Clearly the lady, and the ACOG regulators, believe that the sexual drive is irresistible, hence have rewritten the definition. Natural family planners believe otherwise, and wish to see the distinction between NFP and contraception maintained. (See # 3)

3. Retention of the erroneous definition allows multi-method family planning providers to claim credit for NFP provision. This cheats the would-be NFP user and often offends her/him morally, and allows the provider to claim to be within Title X guidelines for purposes of reimbursement from the Regional Office.

NFP providers have ethical objections to the mandatory demand for referral or provision of "all family planning services" (Regulations, Sec.7.4) which are a precondition for receipt of Title X funds. Some NFP providers object from religious grounds, others believe that any medical risk (inherent in oral or injectable contraceptives, some local methods, and sterilizations) is unjustifiable when the condition "treated" is normal physiology. This risk is recognized in the Regulations, which demand regular medical supervision for the recipients of the first two modalities and permit their omission for non-prescrition methods (Reg. 8.3) While periodic pelvic examinations and Pap. smears are highly desirable they are not an intrinsic component of NFP which is health education, not medical treatment.

Additionally, many NFP providers are reluctant to refer persons who choose contraception to any unknown provider, since the NFP provider may lack comptence to judge which clinics or physicians can provide other services competently.

I SUGGEST therefore, that in place of the current regulations which favor fertility control by technological means, that the Congress, if it reauthorizes Title X, direct the Department of Health and Human Services to regulate the implementation of the Act to assure economic access without philosophical bias and with full respect for the conscientious, ethical and religious beliefs of recipients and providers.

Respectfully,
Hanna Klaus
Hanna Klaus M.D.
Executive Director
Natural Family Planning Center
of Washington D.C. Inc.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
OFFICE OF THE ADMINISTRATOR

TO : Regional Health Administrators, PHS
Regions I-X

DATE: APR 8 1979

FROM : Administrator

SUBJECT: Bureau of Community Health Services (BCHS) Regional Memorandum 79- 12
Natural Family Planning Services

Provision of natural family planning (NFP) services as a method for family planning has recently been emphasized by Congress in the context of the amendments to Title X of the Public Health Service Act made by P.L. 94-63 and P.L. 95-613. Senate Report 95-822 stresses "... new emphasis on the provision of family planning services to sexually active adolescents and to members of both sexes who want to avoid unwanted pregnancy ... to respond to criticism of the program by stressing natural family planning methods in each of the programs ...."[1]

This memorandum describes the Department's efforts to improve the provision of NFP services by grantees, and clarifies the Department's position on NFP services.

Since 1975, the Office for Family Planning, BCHS, has initiated activities through the services delivery improvement research funds and funded NFP studies in order that assistance can be provided to the grantees. These studies include biregional conferences on NFP; testing of a freestanding NFP clinic; development of a curriculum outline for training of NFP instructors; and a grantee needs assessment survey to assess the technical assistance needs in order that appropriate assistance can be planned for and provided. The Requests for Proposal for the funding of five biregional NFP workshops in 1979 as a followup to the biregional conferences, was published in the Commerce Business Daily on February 8, 1979. The NFP curriculum was distributed in March 1979.

The position of the Health Services Administration relating to the provision of NFP by Title X projects is as follows:

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[1] Senate Report No. 95-822, Voluntary Family Planning Services, Population Research, and Sudden Infant Death Syndrome Amendments of 1978, Report of the Committee on Human Resources, United States Senate, To Accompany S. 2522, Washington, 1978, page 14.

1. What is NFP? The use of NFP to avoid a pregnancy denotes abstinence from intercourse during the woman's fertile period. The techniques for recognizing the woman's fertile period are many, the most acceptable being the ovulation method (OM), basal body temperature method (BBT), and the sympto-thermal method, which incorporates OM, BBT, and other physical signs. These techniques are defined as "fertility awareness" techniques.

2. NFP Services. All Title X projects must offer NFP as a method for family planning either onsite or through referrals. Since NFP requires an educational delivery system as well as intensive, high-quality counseling by qualified instructors, projects are advised to utilize existing resources wherever feasible. It is recommended that all BCHS programs offering family planning services incorporate fertility awareness as part of the information and education services.

3. Options for Funding of NFP Sites. The Title X Notice of Proposed Rulemaking (43 FR 42020, September 19, 1978) describes as follows the longstanding Department position on the funding of NFP providers under Title X:

> "A facility or entity offering only natural family planning, can participate in a project as long as the entire project offers a broad range of family planning services."

Consistent with this position, the following two options are permissible means for Title X grantees to fund NFP providers:

(a) funding an NFP service provider as a delegate agency for special services; or

(b) contracting with an NFP service provider to function as a referral site for the grantee under a reimbursement for services arrangement.

4. Patient Management

(a) Information and Education

Under either of the above funding options, certain other considerations will have to be accommodated. Specifically the regulations require that all projects receiving family planning funds must provide a broad range of family planning services. In addition, the statute and regulations require that acceptance of family planning services be "voluntary." Implicit in these requirements is a requirement that information on all methods of contraception must be provided by the service provider. In addition, in interpreting the "voluntariness" requirement, the "Program Guidelines for Project Grants for Family Planning Services Under Section 1001 of the Public Health Service Act," which applies to such projects, state that projects should obtain informed consent to the provision of family planning services.

The following arrangements between grantees and NFP providers are acceptable methods for complying with the above requirements:

(1) FOR ALL PATIENTS REFERRED TO THE NFP PROVIDER by the grantee or delegate agency, the referring agency has the responsibility of ensuring that the patient desires and seeks NFP services only; and

(2) FOR ALL NEW CASES that come directly to the NFP provider, the NFP provider has the responsibility of (a) providing the information on all contraceptive methods; OR (b) referring the patient to the grantee or nearest Title X clinic that offers the required information as specified under the Title X guidelines.

If the patient, when offered the opportunity to be advised about other methods of contraception, affirms the decision to seek NFP services only and rejects consideration of other methods, the NFP provider does not have to provide such information. In such a case, however, it should obtain a release form from the patient which states that he/she is seeking NFP services only.

(b) Medical Examination

The Title X regulations require grantees to provide medical services related to family planning, including "physician's consultation, examination, (and) ... continuing supervision ...." All NFP providers which are part of Title X projects must comply with this requirement and offer a physical examination either onsite or through referral arrangements.

If the patient reports that a physical examination was done during the last 6 months, the NFP provider must either obtain a copy of the record of the examination and keep it in the patient's medical record, or perform another examination. If the patient refuses to undergo a physical examination, a signed statement of refusal must be obtained and placed in the patient's medical record. The patient will then be eligible to receive NFP services.

Should your staffs have any questions concerning this matter, please have them contact Mr. William J. White, Acting Associate Bureau Director for Family Planning, at 8 443-2430.

George I. Lythcott, M.D.
Assistant Surgeon General

Senator DENTON. Thank you, Dr. Klaus.

There is one thing I do not understand, and I am probably the only one in the room who does not. You say, "As late as 1980, 90 percent of NFP services were provided by the private sector," and then you go on to say, "Worldwide, method failure rates of modern natural family planning methods range from 0 to 2.8 percent."

Dr. KLAUS. Yes.

Senator DENTON. I assume that means for people who are trying to avoid pregnancy for the year or something, up to 2.8 percent might become pregnant, or down to none would become pregnant.

Dr. KLAUS. That is correct.

Senator DENTON. Then, you go on to say, "While informed choice pregnancies"——

Dr. KLAUS. Those are people who know their fertility patterns, have stated at the beginning of their cycle that their intention was to avoid pregnancy, but made a spur of the moment decision; in order to separate those from people who come in at the beginning of the cycle and state that they are using the method to achieve pregnancy, we have made that distinction.

Senator DENTON. Their informed choice pregnancy failure rate is 0.3 percent to 6 percent in India; is that what you said?

Dr. KLAUS. That is right, and where it is not so important to avoid a pregnancy, for instance, in Latin America, it goes as high as 23 percent. What I am trying to say is if people want to use this method, they can make it work for them; if they do not, it will not.

Senator DENTON. Over 23 percent in Latin America?

Dr. KLAUS. That is right.

Senator DENTON. How would you label that—uninformed choice, or——

Dr. KLAUS. No, I would label that a very tricky protocol. That was the mirror image of the Los Angeles Study. These people had to keep very complicated records and come in for monthly blood tests, and frankly, I think they voted with their feet.

Senator DENTON. Can you elaborate on the results of your fertility awareness for the teen pilot project?

Dr. KLAUS. We had over 200 girls in the program, in excess of 12 months. They were no younger than 15 at entry. Parental consent was required, and an overview of the program given. Confidentiality of the girls was assured. They were given full instructions in the Billings method over time—at least every 2 weeks for the first 3 months; then, once a month for 3 months; and then every 3 months until the program ended.

We assured the girls of confidentiality, but by having parental consent forms signed by them and their parents, the bridge was established so that they could talk about their values and expectations.

There was only one informed choice pregnancy, which in a sense, shows that we are still dealing with the human condition, and that people will always make free choices. But they are much lower than, for instance, Zelnik and Kantner's rates for pregnancy for an age-matching group.

Senator DENTON. If I am reading this correctly, you say that your pilot study detailed in the testimony shows that obtaining parental consent prior to providing fertility awareness/natural family planning to adolescent girls neither undermines the program nor does it produce an increase in sexual activity or teen pregnancy.

Is that equally true for fertility awareness and natural family planning—in other words, when the girl comes to you to get information on that, you do either permit the parent in, or when the parent does become involved, there is no increase in sexual activity or teen pregnancy; is that what you are saying?

Dr. **Klaus**. Yes, Senator. What happens is that fertility awareness as we teach it is natural family planning. No one is invited to become sexually active. On the other hand, they have enough information. But in the followup, we always discuss, "What does this do to you, this knowledge? What does it do to your discovery of yourself as a woman, of your powers—are you ready for a baby?" If not, there is only one sure way. And most kids have life goals, and if you help them to look at them, they are very happy to postpone becoming a parent until they grow up.

By fertility awareness we teach them their signs of cyclic fertility, with full information, but then we stay with them long enough to make sure that they do understand the implications.

Senator **Denton**. You mentioned that the Department of Health and Human Services regulations for title X have caused a problem of conscience for many natural family planning providers.

Dr. **Klaus**. Yes, it is the referral clause. A number of people felt they could not even request Federal moneys, because of the provision which says that you must be willing to refer for artificial contraceptives. There are many people who have religious barriers against doing this. It is a conscience problem—because they consider artificial contraceptive a moral evil, and they could not participate. But ways have been found to handle this by simply referring back to the umbrella, or simply having a statement which says people know that when they come into these programs, they are only looking for natural family planning. If they are looking for something else, this is not the place. That has been accepted in some regions and not in others.

Senator **Denton**. Could you write and submit later your version of a conscience clause in the bill that would allow providers who refuse to refer to other providers for artificial methods to receive funds, so that we could consider it?

Dr. **Klaus**. Thank you. I will be glad to.

Senator **Denton**. Thank you, Dr. Klaus. We might be submitting other questions to you in writing, and we will ask you to respond in writing. Thank you very much for your testimony this morning, Dr. Klaus.

Senator **Denton**. Our next witness is Mrs. Connaught Marshner, the director of the Child and Family Protection Institute.

Dr. Breen, we just overlooked your plane problem.

Dr. **Breen**. I am fine, Senator.

Senator **Denton**. All right, sir. You are very kind. Thank you very much.

It has been my privilege to associate with Mrs. Marshner in this field for many years. We appeared together on the MacNeil-Lehrer Report. Asking her questions is like asking, perhaps, your mother questions about how to be a parent. But I am glad you are here this morning, Connie, and please begin with your statement when ready.

STATEMENT OF CONNAUGHT MARSHNER, DIRECTOR, THE CHILD AND FAMILY PROTECTION INSTITUTE

Mrs. **Marshner**. Thank you, Senator.

I think the age difference is such that maybe, asking you questions is like asking my father questions.

But anyhow, I will summarize as briefly as I can the written statement, because you have that.

At the time title X became law in 1970, it was rationalized on several grounds. One was the need to curtail the number of illegitimate births. The other was the need of Congress to respond to what I can only describe as the population explosion mania which was then sweeping the country. Congress was not exempt from that trend of alarmism, and the high compliments that were paid to Congress by the population crisis spokesmen about the prudence and wisdom of allocating funds for population no doubt felt good at the time.

I want to take issue, however, with that population explosion mania. I think, by all indicators, the first problem has not been addressed. Illegitimacy, venereal disease, pregnancy, and so forth, have gone the opposite of down. But I submit that for Congress to continue to the population control lobby is contrary to the best interest of the United States, and also demeaning to American citizens.

Let me just quote a few news articles of fairly recent vintage, and these are only pointing out the tip of the iceberg.

The New York Times, April 10, 1983, headlines: "Study Sees Labor Shortages Ahead for Cities. A new study suggests that New York City and perhaps many others in the nation may experience labor shortages before the century is out." The author of the study was Regional Commissioner of the Federal Bureau of Labor Statistics in New York City for many years. The shortages would be caused by two factors, he said. The first is that some concerns are encouraging workers 55 and over to take early retirement. The second is the decline in the birth rate during the 1960's, which means that younger workers may not be available in certain areas to replace the older ones.

New York Times, December 15, 1982, headlines: "Social Security at Crossroads"—an issue that the Senate is very well familiar with.

The real crisis in the system will not come until after the year 2010, when the post-war baby boom generation begins to reach retirement age. The crisis will reach its peak around 2030, when the ratio of active workers to retired people will drop to an estimated of 2½ to 1 from the ratio of 5 to 1 today, and a bit more than 4 to 1 in the year 2000.

George Perry of the Brookings Institution points out that it is important to realize that a drastic cut in benefits for retired people, or alternative, much greater sacrifices by working people, will still be necessary and just about as severe, whatever the level of benefits may be.

With your permission, I will submit the entire articles for inclusion in the written record, as well as some others.

Senator **Denton**. Without objection, the articles will be included in the record. I am sure you are aware, Mrs. Marshner, that this is not only an American problem, but it is a Western problem, and that Germany has much less favorable birth rates in the terms that you have just——.

Mrs. **Marshner**. Oh, indeed. We are following Western Europe, which is on a very steep downward slope.

Our Census Bureau is projecting that our population will peak around the year 2050 and will then absolutely decline. The 1983 saw a 2-percent decline in the rate of birth over 1982—in the number of births. It should be a rather sobering thought to realize that the number of teenagers in the country will never rise above the 1980 level. That is what the Census Bureau is saying, that there will never be any more teenagers than there were 4 years ago. Now, that seems to be sort of a sobering fact.

The Population Reference Bureau, which is one of the anti-baby think-tanks, acknowledges that its findings are really not significantly different from the Census Bureau's in this area.

Now, in the late Sixties and in the early Seventies, there was a whole lot of talk about urging coercion to cut out the so-called "cancer" of population growth.

The Wall Street Journal of September 16, 1969, for instance, ran an article by Jonathan Spivak, which urged removal of tax exemptions for children and other modifications of the Federal income tax policy to favor the single wage-earner at the expense of married couples; the denial of college educational benefits to children of large families; open approval of homosexuality and other deviant behavior which cannot cause conception; encouraging women to continue their education or obtain employment, since birth rates are low among Ph.D.'s and working wives; the addition of a fertility—depressing chemical to the water supply. In the light of proposals like that, I guess the $6 million for 1970's appropriation for so-called "voluntary" family planning seemed a very modest step, indeed. And it is, theoretically, voluntary. But I want to question how voluntary it actually is in practice. And let me give you the following scenario.

Supposing you are a poor woman, married. You have your baby at the county hospital, which of course, receives the full gamut of Federal family planning funds and accepts the ideology of population control. You arrive at the hospital in labor—in this case, say, for a repeat cesaerean section. When you are lying on the stretcher, waiting to be taken up to the delivery suite, an intern comes up to you with a form to sign. It is a consent to sterilization. He calls it a "tubal ligation." Unless you happen to be knowledgeable, you will not know what he is talking about. You refuse to sign it.

"Well, how many C-sections are you planning to have?" he asks, very insultingly. You go upstairs. Now, it so happens that medical practice frowns on allowing unsupervised labor for any length of time for a woman with a history of previous C-sections. Yet, you are left virtually unattended in the labor room for close to 4 hours. Finally, they administer a local anesthetic and wheel you in.

They begin the operation. The baby is born. It is a fine, healthy child. As the doctor is sewing you up again, once more you are asked whether you are sure you do not want your tubes tied, and once more, you refuse. A day later, a social worker comes around with the birth certificate to fill out, and the family planning worker follows close behind to peddle you some birth control methods.

Six weeks later, you go for your post partum checkup. You find out that the maternity clinic will not see you. You have to go to the family planning clinic. And the first question they ask you is: "What method of birth control are you using?"—not "How are you? How is your incision healing? How is the baby?" No. "What birth control method are you using?"

They refuse to give you your checkup unless you consent to receive birth control information and, presumably, materials.

Now, I ask you what kind of voluntariness is this? If you happen to be a minority woman, in addition to being poor, or you happen to have a language barrier, let alone not being familiar with the medical jargon that they use, and you are overwhelmed and intimidated, if not downright scared, how many times do you think you would really be able to resist their efforts to sterilize you, or to fill your body with foreign objects or hormones? Oh, you would sign the forms, all right, but you would technically be giving your consent. The letter of the law would have been complied with. It would have been a voluntary procedure. But I wonder.

Senator **Denton**. I will have to ask you to stop the statement at that point.

Mrs. **Marshner**. Fine. I understand. I made my point, I think.

Senator **Denton**. I will try to bring out the rest of it with a question.

Is that a theoretical postulation of a scenario which you have just offered? Is that something that you have made up in your mind about what might happen to a young woman who goes to the hospital, pregnant or is it a true story?

Mrs. **Marshner**. That happened to me.

Senator **Denton**. That happened to you?

Mrs. **Marshner**. That is my experience. And I have no reason to believe that I was treated any different from any other patient in the Dallas County health system in 1977. That was their standard procedure.

And I just happened to be lucky, because I had had a baby before, and so I knew what was going on. I knew what they were trying to do, I knew the terminology. Had I not known what was going on, I would have been in a very poor position to protect myself.

Senator **Denton**. Regarding the question of voluntary participation in the family planning program, is pressure exerted on individuals, and if so, how can Congress help to eliminate it?

Mrs. **Marshner**. Well, the pressure comes from the system and from individuals who are playing their roles in the system. For instance, the hospital knows that it will receive money for each person that accepts family planning, so there is a built-in incentive there to get more people to take the family planning services. Also, the individuals—the medical students, interns, residents, doctors, or whatever they are—have gotten the attitude from their training, or from wherever they get their attitudes, that their function to benefit society is to minimize the number of babies born. Thus, they are personally zealous, and the hospital, of course, has its financial interest in providing as many of these services as possible. So, to think that it is voluntary, in a regulation or in a law, is to set a hypothetical standard which does not stand up to the reality of pressure exerted, maybe even in voluntarily, by the zeal for controlling population and for financing the hopsital. Attitudes cannot be controlled, and they are what influence the inarticulate, ill-educated woman. And for the Federal Government to be part of the system which creates the mentality that it's the Government's job to prevent a baby is for the Government to be on the wrong side of it.

Senator DENTON. Mrs. Marshner, have you participated or been asked to participate in any advisory councils that the Office of Family Planning has created?

Mrs. MARSHNER. No. I have not sought to be, but I have not been asked.

Senator DENTON. Do you see any ways in which members of the profamily community could participate in the provision of information and services to low-income women, or do you just categorically condemn any program for such women?

Mrs. MARSHNER. I don't condemn voluntary programs. What I object to is for the Federal Government to be in the position of providing family planning. I object to granting the principle that it is appropriate for Government to exert pressure on people to make certain fertility decisions. Once that principle is conceded—and title X has, in fact, established that principle—as have other laws, as well, then the consequent principle also has in fact been granted, namely, that Government may appropriate to itself the right to make those decisions, then it is only a matter of time, a timetable, whether or not, or when, the Government starts making fertility decisions for its citizens.

So, in the private sector I do not object, provided family planning is voluntary. If people want to buy it, if doctors want to do it, if private organizations want to finance it, let them. But I do not think that the Federal Government ought to be lending its moral authority and its legislative authority to forcing family planning on its citizens.

Senator DENTON. Do you have any other points you would like to add? We will be submitting questions to you in writing, for which we ask written responses.

Do you have anything else you wish to add to your testimony before we excuse you?

Mrs. MARSHNER. Well, I think that in the interest of time, I will respond to your written questions. I would just point out that when your colleagues come to vote on this reauthorization, I think that it would be a great service to this Nation if the question could be posed to them: "By reauthorizing this program do you realize that you are putting the Government in the position of saying, 'We, the Government, have the right to control people's fertility'?". Ask the question to them that way, so that that is what is answered. I think that would be helpful to history.

Senator **Denton**. We welcome any methods of persuading colleagues to see what you regard as the truth and what I regard as the truth so far and solicit your advice in that regard and hope that it is forthcoming.

Thank you very much, Mrs. Marshner, for your help this morning.

Mrs. **Marshner**. Thank you, Senator.

Senator **Denton**. I must say, I think no one could mistake you for being my mother. I was trying to defer. Thank you.

Mrs. **Marshner**. Thank you, Senator.

[The prepared statement of Mrs. Marshner follows:]

TESTIMONY OF CONNAUGHT MARSHNER
CHAIRMAN, NATIONAL PRO-FAMILY COALITION
APRIL 5, 1984

I. IS IT WISE?

At the time Title X became law in 1970, it was rationalized on several grounds. One was the need to curtail the number of illegitimate births. The other was the need of Congress to respond to waht I can only describe as the "population explosion mania" then sweeping the country. By that I mean the rash of popular books and magazine articles, and the making into folk heroes of those who predicted gloom and disaster because of too many people in the world. I remember Life magazine reporting that by 1980 urban dwellers would have to wear gas masks to breathe, and in the 1980's a smog inversion would kill thousands of people in a major city. Congress was not exempt from hearing this kind of alarmism, and the high compliments paid to Congress by the population crisis spokesmen about the "prudence and wisdom" of allocating funds for population research no doubt sounded good at the time.

And so the mechanisms fell into place, and since 1970 the United States has spent upwards of one and a half billion dollars on the Family Planning and Population Research Act in all its aliases.

How to evaluate the fourteen years in between? By all indicators, the problem I first mentioned has not been addressed. Rates of illegitimacy, veneral disease, and teenage pregnancy have all increased astronomically, as, of course, has the abortion rate. I will not belabor this point; others can document it better than I.

I want to take issue with the population explosion mania. I submit that for Congress to continue to pander to the population control lobby is contrary to the best interests of the United States, and, also, demeaning to American citizens.

A typical recent example of the anti-people mentality is the Pasadena, California Plannied Parenthood brochure which proclaims:

> "Rapidly increasing population. . . (produces a) growing number of uneducated people who can become neither worthwhile employees nor customers. . . The

> solution ...is...to decrease sharply the rate at which children are being brought into the world.... "

This kind of mentality assumes that people are problems. It seems to me that there is more to life than being an employee or a customer, frankly, and I would like to suggest that the authors of that pamphlet would not be very good customers, employees or anything else unless somebody had made an effort with them -- their teacher, their parent, their friend, some other human being, some other person who had to first be brought into the world.

Some of the advocates of what I refer to as the "ban the baby" movement operate out of a misguided humanitarianism: they want poor people to have a better life, and they think depriving them of children will give it to them. Some are preoccupied with the dichotomy between the haves and the have-nots, and jealous to protect themselves from supporting too many have-nots at public expense. Of course, if the welfare state were not so thoroughly entrenched and expanding its grip on all of us, this motivation would not be as credible as it sometimes seems. I further suggest that when the have-nots happen to be of a different color than the haves, that the motivation of racism is strongly admixed with the motivation of good old stinginess.

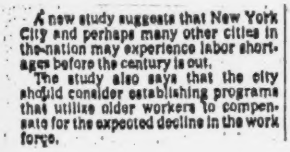
Then there are those who think that preserving snail darters is more important than providing for the needs of people -- as if inanimate nature had more intrinsic value than human nature. And, of course, there are some old ideas: elitism, which says, we know better than you what is good for you and everybody else; and eugenics by other names, which says that human beings should be bred for brains and other indicators of "fitness", fitness, of course defined according to an elitist, WASP scale. These are the ideas which are being fed and financed by federal family planning.

The monies for programs go to the exponents of these "ban the baby" ideas at the grassroots level, witness the Planned Parenthood brochure quoted earlier. Children by choice -not by chance remains the slogan. But the persuasiveness is biased in the direction of sterility. The monies for research go to the people dedicated to the proposition that controlling population is mankind's greatest need. In 1971 the

Population Crisis Committee published an interesting booklet. Various experts in the stable of the Crisis Committee expounded on all the different areas of population control that needed to be researched: everything from brain hormones, to antibodies, to prostaglandins, to male contraceptives, to sterilizations, to behavioral sciences, and proposed dollar figues for how much was needed to do the research. In 1971, these experts came up with a price tag of $ 288 million per year to begin to meet their research needs. In 1983, the National Institute for Child Health and Human Development alone had a budget of $86 million for population research. I can't help but wonder why government should be the one to fund this research -- after all, when a new contraceptive is invented and sold, it isn't the federal government which receives the profits, so why should it be the federal government which is out the cost of the research?

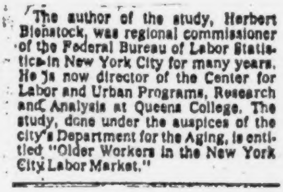
I repeat my original question: is this expenditure of public monies to limit the size of the American nation wise? Let me quote a few news articles of recent vintage.

The New York Times, April 10, 1983. Headline: "Study sees Labor Shortages Ahead for Cities."

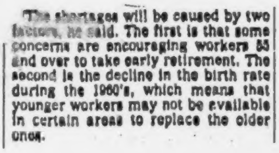


A new study suggests that New York City and perhaps many other cities in the nation may experience labor shortages before the century is out.

The study also says that the city should consider establishing programs that utilize older workers to compensate for the expected decline in the work force.

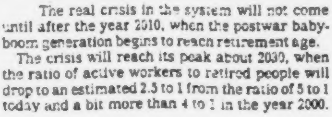


The author of the study, Herbert Bienstock, was regional commissioner of the Federal Bureau of Labor Statistics in New York City for many years. He is now director of the Center for Labor and Urban Programs, Research and Analysis at Queens College. The study, done under the auspices of the city's Department for the Aging, is entitled "Older Workers in the New York City Labor Market."



The shortages will be caused by two factors, he said. The first is that some concerns are encouraging workers 55 and over to take early retirement. The second is the decline in the birth rate during the 1960's, which means that younger workers may not be available in certain areas to replace the older ones.

The New York Times, December 15, 1982. Headline: "Social Security at Crossroads".



The real crisis in the system will not come until after the year 2010, when the postwar baby-boom generation begins to reach retirement age.

The crisis will reach its peak about 2030, when the ratio of active workers to retired people will drop to an estimated 2.5 to 1 from the ratio of 5 to 1 today and a bit more than 4 to 1 in the year 2000.

> Some critics of the present system argue that benefits should be reduced drastically now to build up a huge surplus in the trust fund that could be drawn down later to support the retired population when it is exceptionally large.
>
> But George Perry of the Brookings Institution points out that it is important to realize that a drastic cut in benefits for retired people or, alternatively, much greater sacrifices by working people will still be necessary and just about as severe, whatever the level of benefits when the baby-boom people retire after the first decade of the next century or in the years leading up to that time.

With your permission, I submit the entire articles for inclusion in written record.

The Census Bureau is now projecting that our population will peak in the year 2050, and then decline, as deaths outnumber births. Nineteen eighty-three saw a 2% drop in births over 1982. It should be a rather sobering thought to businessmen to realize that the number of teenagers in the country will never rise above the 1980 level, yet that is what the Census Bureau now tells us. The Population Reference Bureau, one of the anti-baby think tanks, acknowledges that its findings are not substanially different. United States population has been declining since the late 1960's, even as the rhetoric of population mania heated up, and even as legislation like this was enacted.

Garrett Hardin and Paul Ehrlich, among others in the late 1960's and early 1970's, were urging coercion to cut out the "cancer of population growth". Other so-called opinion makers were advocating intermediate steps. The Wall Street Journal of September 15, 1969, ran an article by Jonathan Spivak which urged:

--removal of tax exemption for children and other modifications in Federal income tax policy to favor the single wage earner at the expense of married couples;

--denial of college educational benefits to children in large families;

--open approval of homosexuality and other deviant behavior which cannot cause conception;

--encouraging women to continue their education or obtain employment -- birthrates, not unexpectedly, are low among PhD's and other working wives;

--the addition of a fertility depressing chemical to the water supply.

I suppose in light of all these proposals, that a mere $ 6 million in Title X for government provision of voluntary family planning services seemed a very modest appropriation indeed.

II. IS IT VOLUNTARY?

It is, theoretically, voluntary. But I question how voluntary it actually is in practice. Consider the following scenario. You are a poor woman, and you have your baby at the county hospital. When you come into the hospital in labor, in this case, for a repeat cesearean section. When you are lying on the stretcher, waiting to be taken up to the delivery suite, an intern comes to you with a form to sign. This is to consent to sterilization. He calls it a tubal ligation. You refuse to sign it. "Well, how many c-sections are you planning to have?" he asks insultingly.

You go upstairs. It so happens that medical practice frowns on allowing unsupervised labor for any length of time in women with a history of previous cesearean sections. Yet you are left, virtually unattended, in the labor room for close to four hours. Finally, they administer the local anesthetic and wheel you in. They begin the operation. The baby is born--a fine, healthy child. As the doctor is sewing you up, once again you are asked whether you are sure you do not want your tubes tied. Once again you refuse.

A day later, the social worker comes around with birth certificate forms to fill out, and the family planning worker follows close behind to peddle you some birth control method.

Six weeks later you go for your postpartum checkup. You find out that the maternity clinic will not see you. You must go to the family planning clinic. The first question they ask you is what form of birth control you are using. Not: how are you? how is your incision healing? how is the baby? No -- what birth control are you using? They refuse to check you unless you consent to receive birth control information, and presumably materials.

Now, I ask you: what kind of voluntariness is this? If you happened to be a minority woman in addition to being poor, and did not have a command of the English language, let alone familiarity with medical jargon, and were overwhelmed and intimidated if not downright scared -- how many times do you think you would resist their efforts to sterilize you or fill your body with foreign objects or hormones? Oh, you would sign the forms all right, you would technically give your consent. The letter of the law would have been compiled with; it would have been a "voluntary" procedure. But I wonder.

I happen to know the scenario I describe because I was the patient. I was probably the best educated patient to come through that system in months. Because this was my second baby I knew the terminology, and I knew what they were trying to foist off on me. Most women do not enter the system so well prepared. The way I finally got my postpartum checkup was to formally protest that I refused to discuss family planning. Somewhere in the files of Parkland Memorial Hospital in Dallas, Texas, you find an annotation in my file: "Patient objects to government family planning." It was a cursory checkup, by the way.

Yes, I do object to government family planning. Once the principle is granted that it is appropriate for government to exert pressure on individuals in their decision about their fertility, the principle has also been granted that government may appropriate to itself the right to make those decisions for them. Whether, or when, government chooses to exercise that right is a matter only of timetable. Currently, if you are of limited IQ, or likely to have children of limited IQ, in some states the courts have the right to sterilize you -- for the benefit of society, of course. If you are poor, minority or poorly educated, you are easy prey to the public health facilities which percieve their obligation to society as controlling the fertility of American women. In other words, only if you are able to afford private medical care is your fertility a private matter. Title X bears the substantial amount of the responsibility for bringing this situation about.

III. SUMMARY

We are probably the first generation in the history of mankind which is being told that children are an evil, and a menace to the human race. The anti-baby mentality is marked with fatalism, pessimism, and, essentially, distrust of our own humanity and our fellow human beings.

We are teaching our children to deny their own human nature, as Title X promotes the idea that the practice of sex need not have any connection with children, and, therefore, need not have any connection with roots, stability, or permanent relationships. This denial of our nature produces only unhappiness in those who attempt it.

But beyond that effect of Title X, the existence of this law puts the United States government on record declaring that it is appropriate for government to decide who has children. Not in so many words, but in principle. It is this principle to which I object.

I thank you, Senator Denton, for the opportunity to express these views. I urge you to ask your colleagues: is this the principle you intend for the U.S. Senate to establish? Do you intend to put the nation on this road to government control of fertility? Ask that question when the vote is taken on reauthorizing Title X, and give your colleagues the opportunity to answer that question.

Senator DENTON. Dr. Breen, I apologize. Would you come foward, sir?

Dr. James Breen is the president of the American College of Obstetricians and Gynecologists, located in Washington, D.C., and I will ask Dr. Breen to begin his statement when he is ready.

STATEMENT OF JAMES L. BREEN, M.D., PRESIDENT, THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, WASHINGTON, DC

Dr. BREEN. Thank you, Mr. Chairman.

In addition to being president of the American College, I am also professor in the Department of Obstetrics and Gynecology of the Jefferson Medical College in Philadelphia, and chairman of the Department of Obstetrics and Gynecology at the Saint Barnabas Medical Center in Livingston.

The thing I am most pleased with is that I have been a practicing physician for 32 years, relating to reproductive health care.

It distresses me to say so, but teenage pregnancy really is a national disaster. It is something that does concern all of us. Although title X is not principally a teen program, it is the only—and I underline "only"—it is the only national program attempting to prevent teenage pregnancies by providing comprehensive contraceptive services to sexually active teens.

For social and medical reasons, these young females should not become pregnant. Every year. 2.5 million women under the age of 18 risk pregnancy because they are sexually active. For them, the medical risks associated with contraception are really negligible when you compare them to the real, measurable health risks of pregnancy, childbirth, or abortion. For them, programs designed to discourage sexual involvement are too late. Almost 85 percent show up at a clinic or a private physician's office because they have been sexually active or are afraid that they are already pregnant.

Our professional standards require that the obstetrician and gynecologist provide health care services to the sexually active teenager, regardless of her age or marital status. Professionals working with adolescents should encourage family involvement wherever possible, and we have said this repeatedly. But when a minor refuses to involve her parents, pregnancy should not be the price she has to pay. It is a very strange punishment.

Policies which prevent confidentiality deter adolescents from seeking care and these policies should be avoided in the interest of their health.

The 1981 reauthorization of title X recognized this. The report language adopted at that time stated—and I quote: "While family involvement is not mandated, it is important that families participate in the activities authorized by this title as much as possible."

We urge you to reemphasize this sound policy of the voluntary nature of family involvement when teenagers seek family planning services and the importance of confidentiality.

We support the exclusive use of title X funds for services designed to prevent unintended pregnancies. Secretary Heckler reported neither the Inspector General nor the General Accounting

Office have found evidence that clinics are violating the law with respect to the existing prohibition on the use of title X funds for abortion. However, it is the ethical, as well as the professional responsibility, of the obstetrician and gynecologist to make sure the female patient is fully aware of all of her alternatives—that is, all of them—both in preventing pregnancy and when pregnancy is diagnosed.

We would oppose any attempt to withdraw title X support from providers because they offer this comprehensive counseling.

Similarly, we are opposed to efforts to withdraw funds from providers on the basis of lawful activities, conducted with public or private funds other than title X.

Finally, I should like to discuss the research component of title X, and the need for further research in the area of contraceptives. The fact is, there is no superb contraceptive available from those of us in the private sector or those in the public sector.

More than half of all pregnancies in the U.S. are not intended. The fact that nearly half of all the unintended pregnancies end in abortion underscores the need for research on improved contraceptive technology. The Office of Technology Assessment identified eight major areas where additional funds could reap tremendous payoffs, and we would urge an increase in the budget to expedite research efforts along this line at NIH.

The American College of Obstetricians and Gynecologists is convinced that title X family planning is successful—it has been in the past; it will be in the future—and should be reauthorized as a separate categorical program. Services to teenagers should be reemphasized due to the large number of sexually active women in their age group and the negative consequences of teenage pregnancy. Confidentiality of services and consideration of teens on the basis of their own financial resources should still be continued. And, in light of the instance of abortion, increased effort is needed in the area of contraceptive research and development to provide women better means of avoiding unintended pregnancies.

This concludes my testimony. I appreciate very much the opportunity of being here, and I would be delighted to respond to any questions as well as I can.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Breen and responses to questions submitted by Senator Denton follows:]

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

TESTIMONY OF
JAMES L. BREEN, M.D.
PRESIDENT
THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

TO THE
SUBCOMMITTEE ON AGING, FAMILY AND HUMAN SERVICES
OF THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

APRIL 5, 1984

600 Maryland Avenue, S.W. • Washington, DC 20024 • Telephone (202) 638-5577

I am James L. Breen, M.D., a practicing obstetrician and gynecologist from Livingston, New Jersey, and current President of The American College of Obstetricians and Gynecologists (ACOG). On behalf of The American College of Obstetricians and Gynecologists, I am pleased to have this opportunity to appear before the Subcommittee on Aging, Family, and Human Services as you consider the reauthorization of the Title X family planning program and the related issue of the appropriate federal role in supporting family planning services and population research.

The ACOG represents over 24,000 physicians specializing in the delivery of reproductive health care for women. We support Title X and have consistently encouraged the Congress to maintain a sustained national family planning effort utilizing the capacity now in place in 5,000 organized family planning clinics and coordinated with the services delivered by physicians in private practice.

The benefits associated with successful family planning which affect the personal health and well-being of women and their families cannot be overstated. Most women can become pregnant from the time they are teenagers until they are in their late 40s or rarely in their early 50s. This means that for 30 to 40 years of a woman's average lifetime she is exposed to the possibility of becoming pregnant. Research shows that birth spacing, appropriate timing, and family size limitation are closely related to better maternal and infant health. It is believed, for example, that about one third of the reduction in the United States infant mortality rate since 1960 has resulted from shifts in the age-parity distribution (maternal age correlated with the number of previous deliveries). Hence, reduced infant mortality may be correlated with successful family planning.

The ACOG wishes to applaud the Congress for its continued support for a categorical family planning program. We urge you to oppose folding family planning into a multi-purpose block grant. We recognize that the family planning program is the largest and by far the most politically sensitive of the existing programs the President has repeatedly proposed for inclusion in the primary care block grant. Transfer of program authority to the states would, in our opinion, needlessly politicize the family planning program. It would be detrimental to continued access to and eligibility for services in states which choose to allocate resources elsewhere. Further, the existing uniformly high national standards for quality of medical services delivered by the clinics might be sacrificed under the block grant plan.

Since reauthorization of the Title X family planning program in 1981, a number of issues involving the administration of the program have arisen that have caused us great concern. We feel compelled to speak out at this time in order to reiterate principles we believe are essential to maintaining the integrity of the program and the delivery of all reproductive health care services.

SERVICES TO TEENS

The American College of Obstetricians and Gynecologists has focused much attention on the special health needs and health problems associated with sexually-active adolescents. Our findings indicate that the health, social, and economic consequences of teenage pregnancy are almost all adverse. Maternal mortality and morbidity, and the risk of having a low birth weight infant, are considerably greater among teenage mothers. Ideally, for both social and medical reasons, these young females should not become pregnant; however, 2.4 million minors (teens under age 18) are at risk of pregnancy because they are sexually active. For them, the medical risks associated with prescription contraception are negligible in comparison with the real and measurable health risks of pregnancy, childbirth, or abortion. Among the 529,000 minors attending family planning clinics who use prescription methods, 95 percent (500,000) use oral contraceptives. Concern has been expressed about the risk of cardiovascular disease among teens who use oral contraceptives but there is no statistical basis for this concern. For young women who do not smoke, the risk of cardiovascular disease associated with oral contraceptives is one-fourth or less the risk of death associated with complications of pregnancy among females using no method of contraception.

The Fifth Edition of the ACOG's "Standards for Obstetric-Gynecologic Services" (1982) states: "The sexually active adolescent female deserves special attention because of the high incidence of unintended pregnancy in this population. The gynecologist should attempt to ensure that individuals exposed to the risk of unwanted pregnancy have access to the most suitable methods of contraception." Those Standards also recommend that "(t)he initial evaluation of a woman should be performed by at least the age of 18 years or when she becomes sexually active. . . ." Therefore, in providing health care services to the sexually active female in her teenage years, the obstetrician-gynecologist must provide such services as he or she would with any patient, regardless of age or status of emancipation.

Adolescents constitute a priority population for services in the Title X program. In fact, Title X is the only national program attempting to prevent adolescent pregnancy through the provision of comprehensive contraceptive services, including counseling, education, outreach and referral in addition to basic medical family planning services to sexually active teens.

In 1981, 1.5 million teens under age 20 utilized family planning clinics, and of these 1,185,000 chose prescription methods of contraception. The success of the Title X program in reaching these already sexually active teenagers stems from a variety of factors. A 1980 survey sponsored by the Johns Hopkins Medical School revealed that the assurance of confidentiality was the reason cited by 44 percent of young female patients for their first visit to a family planning clinic; some 33 percent indicated that they had delayed visiting the clinic for an average of one year after becoming sexually active simply because they feared that the clinic would tell their parents.

Our position on mandated parental involvement in the provision of family planning services appears in our Adolescent Reproductive Health Care policy statement: "The American College of Obstetricians and Gynecologists urges professionals working with adolescents to encourage family involvement wherever feasible, but the adolescent should not be denied care and services by reason of such considerations. Policies which prevent confidentiality deter adolescents from seeking care, and should be avoided in the interest of their health." (emphasis added)

In a policy statement entitled "Providing Effective Contraception to Minors", the ACOG squarely faced the issue of a minor's refusal to involve her parents and concluded, "in the case of an unemancipated minor who refuses to involve her parents, a pregnancy should not be the price she has to pay for contraception."

The ACOG's policy is consistent with the language approved during the 1981 reauthorization of Title X which amended the Act to require that "to the extent practical, entities which receive grants and contracts under this subsection shall encourage family participation in projects assisted under this subsection." The Conference Report accompanying that reauthorization stated, "while family involvement is not mandated, it is important that families participate in the activities authorized by this Title as much as possible. It is the intent of the Conferees that grantees will encourage participants in Title X programs to include their families in counseling and involve them in decisions about services." (emphasis added)

We would urge your committee to re-emphasize the importance of confidentiality, and the voluntary nature of family involvement when teenagers seek family planning services. Likewise, we are opposed to a Sense of the Senate Resolution stating that parents should be informed when their children receive "treatment, care, or counseling" services.

In addition to confidentiality, we believe the current policy of determining the eligibility of teens on the basis of their own, not their family's financial resources is of crucial importance. Means tests or other attempts to verify income are typically used in public programs to restrict eligibility and discourage the use of services by all but an intended few. Implementation of such criteria in the family planning program would only serve to undermine the goals of the program, particularly with respect to the high priority placed on serving teens.

Additionally, using the income of the parents or guardian to determine eligibility, which would have been required by the Department of Health and Human Services (DHHS) in regulations published in the Federal Register of January 26, 1983, would necessitate that the teen patient ascertain her parents' income level prior to visiting the clinic. We view this as a thinly disguised attempt to require parental notification prior to the clinic visit.

We believe the current method of determining eligibility for services is most appropriate not only for the teen population, but for the adult population served by the clinics as well. It must be emphasized that family planning is an essential preventive care program for those seeking to avoid unintended pregnancy. It was designed to overcome existing barriers to care, including economic, geographic, and age barriers.

RESTRICTIONS UNDER TITLE X

With respect to services provided to both teen and adult clients, Title X clinics are prohibited by law from using Title X funds for abortion. The ACOG supports this exclusive use of Title X funds for services designed to prevent unintended pregnancy, as opposed to dealing with its consequences. We were pleased to note that neither the DHHS Office of the Inspector General, nor the General Accounting Office in its report issued September 24, 1982, found evidence that Title X recipients were violating the restriction on use of Title X funds to pay for abortions.

ACOG's Standards for Obstetric-Gynecologic Services state that, "Family planning services should include information on reproductive physiology, methods of conception control, and sterilization." The female patient, "should be aware of the availability, effectiveness, and the relative risks of different methods. Conception control is the responsibility of both partners; both male and female methods should be considered." Similarly, the Standards state, "In the event of an unwanted pregnancy, the patient should be counseled about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering it for legal adoption, or abortion. When possible, and with the patient's approval, this counseling should be made available to her partner and to the parents of a dependent adolescent before these difficult decisions are made."

It is the ethical as well as professional responsibility of the obstetrician-gynecologist to make sure the female patient is fully aware of all of her alternatives including all methods of pregnancy prevention and all options when pregnancy is diagnosed. The ACOG would oppose any attempt to withdraw Title X support from providers who offer such comprehensive counseling. Similarly, we are opposed to efforts to defund providers on the basis of lawful activities conducted with public or private funds other than those allocated under Title X.

CONTRACEPTIVE RESEARCH

To this point I have been talking about the services component of the Title X family planning program. However, since its inception, Title X has also had a research component which provides specific authority for the conduct of "research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population". Under this authority and the open-ended authority contained in Title III of the Public Health Service Act, the Center for Population Research (CPR) of the National Institute of Child Health and Human Development (NICHD), conducts the major portion of population research in the United States today. Efforts of the CPR are focused on four major areas of investigation:

- basic research in the reproductive sciences
- contraceptive development
- medical evaluation of contraceptives currently in use, and
- social and behavioral sciences research.

As practicing physicians we are daily reminded of the importance of and need for further research, particularly in the areas of contraceptive development and medical evaluation of contraceptives currently in use. Regardless of whether we are talking about a woman seeking contraception through a family planning clinic or visiting a private physician in his/her office for this purpose, the undisputable fact facing that woman is that there is no perfect contraceptive method currently available to her.

Every woman attempting to choose from among these less than perfect alternatives must weigh a number of competing factors, including effectiveness, safety, and acceptability of the various methods to her. Just as there is no perfect contraceptive for every woman, no contraceptive is perfect for a particular woman throughout her entire reproductive history. As a young woman completing her education or embarking on a career, her needs will be different than when she is a young mother using contraception between pregnancies, and different still when she is older and has completed her family. Her choice of method will be dependent upon characteristics such as age, marital status, personal medical history, lifestyle, and her personal calculation of the effectiveness, safety, and acceptability of the methods available to her.

Partly as a result of concerns about known adverse consequences but also because of unjustified fears about health effects, there was a measurable shift in the 1970s from highly effective to less effective contraceptive methods. Considering that nearly half of unintended pregnancies end in abortion, this trend underscores the need for additional research on contraceptive safety and technology.

The Office of Technology Assessment (OTA) in a February, 1982, report to the Congress entitled, "World Population and Fertility Planning Technologies - The Next Twenty Years" stated that added investments in the area of contraceptive development would be "highly likely to produce payoffs in the form of useful new technologies." The

OTA report identifies 20 new or significantly improved contraceptive technologies that are expected to become available by the end of the century. The most promising of these for the near-term future include:

- safer oral contraceptives
- improved IUDs
- improved barrier contraceptives
- better methods of detecting ovulation to be used in conjunction with periodic abstinence
- steroid implants
- steroid vaginal rings
- LRF-analog contraceptives, and
- prostaglandin analogs to induce menstruation.

The Center for Population Research is exploring many of these promising avenues, including clinical trials which are planned or underway, new drug development, and research on injectable and implantable drug delivery systems. We urge you to consider granting additional budget authority to the CPR to expedite these research efforts and hasten the availability of improved contraceptive technologies.

CONCLUSIONS

In summary, the ACOG is convinced that the Title X family planning program is highly successful and should be reauthorized as a separate categorical program and not as a block grant to the states. Services to teenagers should be reemphasized due to the large number of sexually active women in this age group and the negative consequences of teenage pregnancy. Confidentiality of services and consideration of teens on the basis of their own financial resources should be continued. Family planning funds should not be used to provide abortions, but increased effort is needed in the area of contraceptive research and development to provide women better means of avoiding unintended pregnancy.

This concludes my testimony. On behalf of The American College of Obstetricians and Gynecologists, I want to thank you once again for this opportunity to present our views. I would be happy to respond to any questions you may have.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

May 2, 1984

Mr. Ronald Hunt
Staff Assistant
Subcommittee on Family
 and Human Services
516 Hart Senate Office Building
Washington, D.C. 20510

Dear Mr. Hunt:

Enclosed as you requested are a corrected transcript and Dr. James Breen's responses to the questions posed by Senator Denton concerning the reauthorization of the Title X Family Planning Program.

Sincerely,

Martha Romans

Martha Romans
Government Relations Analyst

MR:dor

Enclosures

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Questions submitted by Senator Denton for Dr. Breen

1. You indicate that the health, social and economic consequences of teenage pregnancy are almost all adverse. Do you have any knowledge or statistics to indicate any adverse effects of too-early sexual involvement?

2. Where do you, as a doctor, draw the line when it comes to writing prescriptions for unemancipated minors without parental notification?

Q. You indicate that the health, social and economic consequences of teenage pregnancy are almost all adverse. Do you have any knowledge or statistics to indicate any adverse effects of too-early sexual involvement?

A. I have no evidence to indicate that there is any right age for initiating sexual involvement; however, once she begins engaging in sexual activity the teenage female exposes herself to the same risks as adult women, that is, the risk of pregnancy and the risk of sexually transmitted diseases.

We know from available evidence that 50 percent of women aged 15-19 report they have had sexual intercourse, with the average age of their first experience being 16. We also know that those who have intercourse before the age of 18 are much less likely to use a contraceptive. Very young teens, between the ages of 12-15, are particularly apt not to use a contraceptive or to use it sporadically. Thus, these females are more likely to risk pregnancy than if they had postponed their sexual involvement.

Most sexually transmitted diseases occur in young people from adolescence to age 25. They are highly contagious and can cause serious, even life-threatening problems. Postponement of sexual activity eliminates the risk of sexually transmitted disease until such time as sexual activity is initiated.

Early age of onset of sexual activity, particularly with multiple male partners, does place a woman at higher risk for development of cervical cancer. Factors such as first marriage under age 20-21, two or more marriages, first coitus before age 20, two or more sexual partners in life, broken marriages and unstable sexual relationships are all significant and warrant annual screening via the routine pap smear test.

Q. Where do you, as a doctor, draw the line when it comes to writing prescriptions for unemancipated minors without parental notification?

A. The law varies from state to state with respect to the provision of contraceptive prescriptions to minors, although a majority of states specifically authorize a minor to consent to medical services for the prevention, diagnosis and/or treatment of pregnancy. In my own practice I don't subscribe to any arbitrary line or cutoff point for prescribing or refusing to prescribe prescription contraceptives. I try to look each patient individually. For example, I would regard a minor who has already had one abortion without the knowledge of her parents and who is living with her boyfriend much differently than a teen of the same age who has not yet embarked upon sexual activity but who feels she is likely to in the future.

Most physicians that I know are reluctant to prescribe oral contraceptives for these young females without parental consultation.

Senator DENTON. Thank you very much, Dr. Breen.

Why do you feel that the high national standards for quality of medical services will be jeopardized if title X is converted to a block grant administered by the States?

Dr. BREEN. If it becomes a State issue, I am afraid it becomes more of a political issue than a medical issue. I think States could use the funding in areas other than for which it is intended. Therefore, I would hate to see it taken out of the aegis of the Federal Government, because when it ends up within the province of the States, I am concerned that the funds will not be utilized in the manner in which they are intended. That would be my main concern, Senator.

Senator DENTON. Well, there is a philosophical difference, you know. Some people think that the closer one comes to the problem, the more likely that doctors, social workers, and educators will be able to meet the circumstances as they exist in their locale. For example, you mentioned your concentration on taking care of already sexually-active children. I have seen movies that were offered under the auspices of some of the title X grantees which contained scenes in which a combined group of apparently sexually active children and, apparently, chaste children. The chaste children seemed to be surprised by what they were hearing, and maybe a little bit shocked, the others who were laughing seemed to fit the category you are mentioning of already-committed sexually active children.

I just wonder if, down in the States, where they have different communities with different patterns of behavior and also, parents knowing to some degree what their children are doing, that they might not be just as interested in the problem as you, or just as qualified as some Federal social workers in drawing the distinction as to when the parents should be involved and whether or not the child is already committed and so on. So there are a number of doctors who testify to the contrary, but I respect your experience and very much respect your opinion. We have no doctor that we chose to oppose you today on that, so I, in all fairness, feel I should say something about it.

You indicate that the health, social, and economic consequences of teenage pregnancy are almost all adverse. Do you have any knowledge, statistics or opinion to indicate any adverse effects of too early sexual involvement?

Dr. **Breen**. I agree with you—I would like that the folkways and mores of society could change and go back to the way they were; but I live in the real world, and I do not think we can look forward to that—I think the concern we have about the teenager, really, is mainly one of pregnancy. The teenager is requesting contraceptive advice, and something very few people realize is that this is her first entrance into a health care system. Last year, 4.5 million women entered a health care system who ordinarily may not have done so. This involves history, physical exams, PAP smears, where the detection rate is very high for venereal disease, abnormalities relating to the internal genital tract. So I think there is a subtle advantage in evaluating and counseling young ladies regarding contraception, in that we can get at that patient and begin to orient them to proper health care standards. I think that is very important, and we very conveniently forget about that.

With regard to your first question, Senator, I realize there are geographic differences in the country. Alabama is different from New Jersey——

Senator **Denton**. And different parts of Alabama are different from other parts.

Dr. **Breen**. Yes; the 36 counties in Alabama are probably all different.

Senator **Denton**. Sixty-seven counties.

Dr. **Breen**. Sixty-seven. All right. There are 36 without a physician. And I really think you have to consider all of these issues. And I really think, when you get into the funding of this, the people who are currently delivering services in the local counties will be the ones who will still do it, but the budgetary control will be, I think, better from a higher level than from a local level. That would be my concern.

Senator **Denton**. OK, I would have to say—you say if it got down to the State, that it might become a political issue—if you do not think it is a political issue now, you did not look at Birmingham during the time one group put up several signs as big as this room.

Dr. **Breen**. That is true.

Senator **Denton**. And I do not have any resources with which to come back and say, "I do not care what married people do in bed," and I do not, and nothing I have ever said here has anything to do with that.

I do believe that parents have to pay for the consequences of some of the things their children do; they have to pay for the health consequences of either venereal disease or pregnancy, or perhaps whatever holdover effects there are from maluse or even use of birth control pills at a very young age, and so on, and therefore, I believe they are entitled, over and above the judgment of some counselor who decides they are not entitled to hear about what is happening to their child in that respect, because they bear the burden of the love, the responsibility, and their visualization of what constitutes the proper pursuit of that child's happiness, and I think they ought to be included in with the counselors, the clergy, the social service providers, and so on. That is just my personal opinion.

Dr. BREEN. Senator, I think there is a misconception somewhere along the line, because those of us who are involved in any sort of family planning spend an inordinate amount of time counseling, and it is our ultimate desire, by pleading and begging and cajoling to have that child somehow enter into a family relationship so we can, hopefully, get them back into a family plan.

Senator DENTON. Then you would be in favor of trying—insofar as practicable—to involve parents; although you say 33⅓ percent indicate that they would stay away from the clinic, have you ever considered that the teenager is going to say anything different from that?

Dr. BREEN. No; I think if you ask a teenager, 50-some percent say yes, their parents do know they are receiving contraceptive advice. I am not sure that is a true statistic.

My problem as a physician is when a child comes from a very poor family situation—and I think the breakdown starts in the family—I have yet to shake a dry hand in the last 20 years—they are scared to death, because they are embarking on sexual activity. They are concerned, are they going to get pregnant, or are they now pregnant. That, to me, represents already a failure on the part of the family unit somewhere along the line. And to try and coerce that child into calling the parents into this when they are vehemently against this, I find goes against my own grain so much. I think it would be wonderful, and I wish we could do this, but in reality, it is a very difficult thing to do.

Probably twice a week, I will see youngsters come in who are involved with incest. Now, how can I call a father who is involved, or a grandfather, or an uncle, and say, "Look, we think we had better put this young lady on contraceptives, because she may conceive through your particular activities"?

That is sort of the situation that we have to exist with. There is no black and white.

Senator DENTON. Well, I would scarcely characterize the national situation that way.

Dr. BREEN. No, that is not the national, no.

Senator DENTON. You know, what strikes me as remarkable is that about half of the kids remain virgins, are abstemious. I do not believe you can cast that half aside in dealing with the problem in a lump sum way. I am not saying that you do, either, but it appears that there is a difference in that direction.

Dr. BREEN. Well, Senator, I rarely see the half that are still in the virginal state. They come in past that point in their lifespan, and there are a certain number who realize they are going to embark upon this journey very soon. They are very intelligent. They come from well-to-do families.

There is one misconception that concerns me very much. I think title X has diminished the gap between those who have and those who have not. The very well-to-do child still goes to the private practitioner. The patient who cannot afford anything will still go to your public clinics, more of these in center cities than anywhere else. I will admit it is a very involved, complex situation that crosses all sorts of political and bioethical lines.

Senator **Denton**. Well, I certainly agree with that last statement, and thank you very much, Dr. Breen, for your testimony.

Dr. **Breen**. Thank you, Senator.

Senator **Denton**. We welcome Mrs. Dorothy Mann, the President of The National Family Planning and Reproductive Health Association.

It is good to be with you again, Mrs. Mann, and would you care to begin your statement?

STATEMENT OF DOROTHY MANN, PRESIDENT, NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC.

Mrs. **Mann**. Good afternoon, Senator. Thank you.

Mr. Chairman, my name is Dorothy Mann, and I am pleased to appear before this subcommittee today. I am a woman, a mother of two children. One is my 15-year-old daughter, who is here in the room with me today. I am a health professional, the executive director of the Family Planning Council of southeastern Pennsylvania, and the president of NFPRHA.

I draw from all of these experiences in presenting this testimony and supporting the continuation of title X as a categorical program.

As a woman and a mother, I know what it means to be able to plan your pregnancy, to get high-quality care to assure healthy babies. I know what it means to talk with and listen to my children as they learn about living in this complex world.

As a health professional, I am aware of the health care my agency provides to the poor women in my community. I know of the PAP smears, the treatment of gynecological problems, the provision of contraceptives, the counseling, the trust and confidence our patients have in our agency.

As the executive director of the council, I am worried that the 17 agencies we fund—the teaching hospitals, the planned parenthood affiliates, the health department and community health centers—are only meeting 42 percent of the need for subsidized family planning care in the Philadelphia area. Even though we serve 90,000 patients, I am frustrated to know that we have not had sufficient funds to open a new clinic site in 3 years.

As president of NFPRHA, I am concerned about the misinformation this committee has used in judging the Title X Program. I am here to offer reality to you, not ideological rhetoric. I will use my remaining brief time to address several myths about the Title X Program.

The first myth: The major purpose of title X is to provide contraceptive services to teenagers. The reality is: No. Can you estimate the percent of our patients who are under 18? Would you guess 50 percent? Thirty percent? In Philadelphia, 15 percent of our patients are under the age of 18, and of those, the majority are 16- and 17-year-olds. Of the 90,000 patients we serve each year, some 1 percent are young teens. And frankly, Mr. Chairman, I do not like the fact that 13-year-olds are having sexual intercourse; I do not like it any more than you do.

The title X program is primarily a preventive public health program, providing services to adult poor women. As such, title X shares infinitely more with the MCH program and the primary care program than it does with the adolescent family life program, and should be administered alongside MCH and primary care.

Myth 2: Family planning providers are a divisive force, separating teens from their families, counseling teens to become sexually promiscuous, and reject the moral and ethical values of their families.

Mr. Chairman, I am pleased to submit for the record, written evidence rebutting this myth. This material, which I am submitting for the record, was gathered by my staff in a survey conducted across this country in early 1981, prior to the parental involvement amendment, to assess the extent to which family planning providers were working with families. These materials show creative and sensitive programs directed at teens, helping them to learn to talk to their families; helping parents be better sex educators of their children; helping parents communicate their standards and values to their children of all ages. After all, good communication, as we know, cannot easily begin in the teen years.

These are voluntary efforts at the community level, without the need for Government mandate. I would guess that since the 1981 family involvement amendment, these programs have expanded in response to the legislative guidance within, of course, the constraints of significant funding cuts.

Regarding counseling, we respect the values and needs of all the patients we serve. We respect the intimate and confidential nature of the service we provide. And as best we can, in the short time we touch the lives of our patients, we provide information to help them make informed decisions.

We work with teenagers to help them tell their parents, in their own way and in their own time, about their clinic visits, and we are succeeding. Forty percent of the patients tell us that their mother knows of their clinic visit on the first visit. Fifty-eight percent know 6 months later, and 15 months later, 72 percent of our patients have told their mothers of their clinic visit.

As you know, Mr Chairman, the vast majority of teens who seek our services have already made a decision to have intercourse. In Philadelphia, that figure is 86 percent. We agree that the reasons for this decision are oftentimes immaturity, pressures from peers, media influences, adult role models, lack of love, and hopelessness about their chances for the future.

Title X cannot alone solve the problem of teen pregnancy. But, Mr. Chairman, we are not the cause of the problem. We are part of the solution.

Myth 3: Family planning programs provide and promote abortion.

The reality is, after 26 audits by the Inspector General, Secretary Heckler stated emphatically this Tuesday that, "Family planning clinics have honored and are in full compliance with the law." Title X programs provide information to the pregnant patient—information about all her alternatives. I would like to submit for the record a pamphlet which describes exactly the kind of counseling that goes on in a family planning clinic. Appended to my written testimony are my agency's guidance on options counseling.

In a free society, coercion is unacceptable. It is not acceptable for a program to push a patient to have a baby, to push a patient to put a baby up for adoption, or to push a patient to have abortion.

There are people who are oftentimes in crisis who see us. We must be sure that these patients have the information they need to make their own decisions.

Mr. Chairman, I thank you for this opportunity to appear before you this morning. I urge you to look at the real title X Program, as you and your colleagues deliberate its reauthorization.

I would be happy to answer any of your questions.

[The prepared statement of Mrs. Mann follows:]

NFPRHA® National Family Planning
and Reproductive Health Association, Inc.

TESTIMONY

OF

DOROTHY MANN

ON BEHALF OF THE

NATIONAL FAMILY PLANNING
AND
REPRODUCTIVE HEALTH ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON THE TITLE X (PHS ACT) FAMILY PLANNING
PROGRAM

APRIL 5, 1984

1110 Vermont Avenue, N.W., Washington, D.C. 20005 (202) 467-6767

Mr. Chairman and Members of the Subcommittee:

My name is Dorothy Mann, and it is my privilege to appear before you today on behalf of the National Family Planning and Reproductive Health Association, Inc. (NFPRHA). In addition to serving my third one-year term as President of NFPRHA, I am the Executive Director of the Family Planning Council of Southeastern Pennsylvania, a position I have held since 1977. Located in Philadelphia, the Council is a private, non-profit corporation established in 1972 to administer federal and state funds for the delivery of comprehensive family planning services to low-income people in Philadelphia and four surrounding counties. The Council is one of four umbrella grantees in Pennsylvania which receive, distribute and administer federal Title X funds.

I very much appreciate the opportunity to testify to the necessity that Congress approve a categorical reauthorization of the national family planning program, Title X of the Public Health Service Act this year. The National Family Planning and Reproductive Health Association is the representative of the diverse community of providers and consumers of family planning services in this country. NFPRHA is a national non-profit membership organization headquartered in Washington, D.C., established to improve and expand the delivery of family planning and reproductive health care services through the United States. Our members -- consumers of family planning services; state, county and local health departments; hospital-based clinics; affiliates of the Planned Parenthood Federation of America; umbrella funding councils; independent private non-profit clinics; and health care professionals -- are committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country. Included in NFPRHA's membership are representatives of over 80 percent of the Title X grantees who, in fiscal year 1983, received over 85 percent of the funds available for family planning services under Title X.

Title X is the primary voluntary family planning program funded by the federal government. Other federal programs provide some support for family services (i.e. Titles V [Maternal and Child Health], XIX [Medicaid] and XX [Social Services] of the Social Security Act). However, Title X is by far the largest single source of funding, providing over 50 percent of available federal support and the national network of family planning agencies through which all subsidized services are provided. The program's goal is to serve a population of approximately 11 million women at risk of unintended pregnancy, including 5 million adolescent women ages 15 to 19 and 6 million adult women ages 20 to 44 in families with incomes below 200 percent of poverty.

The Family Planning Council of Southeastern Pennsylvania and its delegate agencies are representative of the entire nationwide system of grantees and delegate agencies that provide subsidized family planning and reproductive health care services.

During the twelve month period of July 1, 1983 to June 30, 1984, the Council, as a direct Title X grantee, will receive $2,060,000 in Title X funds. During this period, the Council's seventeen delegate agencies will provide services to 91,000 patients, 80 percent of whom have incomes below 150 percent of poverty. This network of 40 clinic sites includes every teaching hospital in the area, as well as community health centers, local health departments, and Planned Parenthood affiliates.

The Council's programs reflect the Title X statute in all areas except basic biomedical and behavioral research. In addition to the provision of comprehensive family planning services, the Council has an active community education program, including a centralized telephone hotline. We receive service delivery improvement funds for service-related research, and we are the grantee for general training of family planning providers in Department of Health and Human Services' Region III. With Planned Parenthood Federation of America, the University of Pennsylvania School of Nursing Continuing Education Program and the Medical College of Pennsylvania, the Council co-sponsors a 16-week OB/GYN Nurse Practitioner Training Program under Title X.

The 91,000 patients in the Council system obtain health assessments, gynecological and breast exams, contraceptive methods and supplies, instruction in breast self-examination, extensive counseling and education, and laboratory tests for anemia, cervical cancer, pregnancy, and venereal disease. A number of our delegate agencies have been especially prepared and supported to provide infertility and genetic risk screening services as well.

The Council has an impressive track record in planning and facilitating significant programmatic growth. In 1976, the Council served 47,500 clients in its family planning clinical services. By the end of this current fiscal year, the annual number of clients served will climb to almost twice the 1976 figure. This increase has been accomplished by expanding the number of agencies and institutions located in areas of documented unmet need for family planning services. Unfortunately, with the reduction in Title X funds enacted at the behest of the Reagan Administration in 1981, the Council has been unable to open a new clinic site in three years. Thus, we are able to meet only 42 percent of the need for subsidized family planning services in our community.

Each delegate agency funded by the Council must include the following services: medical family planning services (history, physical examinations, laboratory tests, and provision of contraceptives and natural family planning methods); patient education, counseling and referral; and follow-up on abnormal results of physical examinations and laboratory tests. The projects may also include community education and outreach to schools, social service agencies, and youth organizations. Specifically, in fiscal year 1983 the Council's seventeen delegate agencies provided the following services to their clients:

Medical	Services Provided
Examinations (including extended, brief, and intermediate)	143,573
Nursing Check	27,110
Cryosurgery	105
Colposcopy	207
IUD's inserted	3,196
IUD's removed	1,698

Lab Procedures	Services Provided
Pap Smear	60,987
Vaginal Smear/Wet Mount	15,972
GC Culture	35,385
Urine Dipstick	62,590
Pregnancy Test (Urine)	29,556
Hematocrit	30,338
Hemoglobin	15,811
Serology	13,680
Rubella Antibody	2,443
Sickle Cell Screening	922
CBC	7,727
Pregnancy Test RRA	1,775

(other lab procedures were provided, but not listed)

Specialized Counseling	Individual Sessions Provided	Group Sessions Provided
Sterilization	1,475	44
Natural Methods	145	27
Pregnancy Options	12,354	72
Teen	13,528	499
Venereal Disease	1,570	172
Sexual	15,130	589
Genetic	248	6
Abnormal Pap	424	9

Nutrition	1,102	77
Infertility	104	4
Mentally Disabled	183	588
Smoking Withdrawal	247	4
Physically Disabled	55	-
Parent/Teen	259	5
Total Sessions	46,824	2,096
Total Counseling Hours Provided	14,721	2,050

Supplies	Supply Units Provided
Condoms	78,262
Foam	28,774
Cream/Jelly	13,231
Diaphragm	6,222
Basal Thermometer	82
Natural Methods Instruction and Charts	18
Medications for Infections	21,271
Rubella Serum	95
Antibiotics for STD	2,761
Oral Contraceptives	380,575

In addition to the direct medical services provided to patients, clients who were seen for initial family planning and initial non-medical visits received comprehensive support services, including basic educational, social and administrative services. Patients who were seen on a routine basis for an annual or revisit received educational, social and administrative services that are generally fifteen minutes or less in length.

Services provided during problem visits, which occur outside the regular schedule of routine or annual visits, include an update of the social and medical history, a review of the problem and, as appropriate, a medical examination, laboratory tests, prescriptions, treatment, special education/-counseling, or referral. Special education/counseling is provided to clients needing assistance to resolve a specific situational problem, generally of a crisis or highly stressful nature.

Among the least understood and most misrepresented aspects of the Council's and other Title X family planning providers' services are the special education/counseling services provided generally to teenagers and to all family planning patients — adult and adolescent — who are diagnosed as being pregnant.

First, it is often alleged that providers of family planning services under Title X advocate, promote and encourage abortion when counseling adolescent and adult women who are pregnant. As often as it is alleged, this misperception is corrected through audits conducted by the United States General Accounting Office, the Inspector General of the Department of Health and Human Services, and other auditors and inspectors. The charge is simply untrue, not only for the Family Planning Council of Southeastern Pennsylvania and its delegate agencies, but for the entire Title X community.

All recipients of Title X funds are governed by the statute and regulations adopted by the Congress and DHHS. Section 1008 of Title X specifically states that "None of the funds appropriated [under Title X] shall be used in programs where abortion is a method of family planning."

Under the regulations adopted by DHHS to implement Section 1008, it has been made clear that staff supported by Title X funds or income related to Title X are prohibited from providing, promoting, or advocating abortion. More specifically, staff in family planning clinics counseling a client with a positive pregnancy test have a responsibility to provide information on all options — prenatal care and delivery, infant care, foster care, adoption, or pregnancy termination — but not to direct the client in reaching a decision.

Further, staff are not permitted to make appointments for abortion or provide transportation to abortion services.

All providers of family planning services under Title X adhere to the letter and intent of the statute and regulations. Most have developed detailed guidelines to ensure that their staff know and understand their obligations; the Council's guidelines are typical and I have attached a copy of them to this testimony for your review. It is clear, however, that good family planning practice, good medical practice, and good public policy is to provide a clinic patient who is pregnant with information and counseling on all her medically correct and legal options regarding that pregnancy. To do otherwise by limiting the ability of family planning clinics to provide non-directional counseling on all options for pregnancy outcome is to deny a pregnant woman her opportunity to make a truly informed decision, and is equivalent to denying a woman information about all her options among methods of preventing pregnancy.

The second area of family planning service delivery and special education/counseling that is consistently misunderstood and misrepresented is that of family involvement in the delivery of services to adolescents. Former DHHS Secretary Richard S. Schweiker provided this country with both the best short description of this misperception — Title X providers "build a Berlin Wall between parents and their children" — and the most ill-conceived "solution" to this misperception — the "squeal rule."

The issue of the "squeal rule" — the proposed DHHS regulations that would have required that family planning clinics funded under Title X notify parents when teenagers receive prescription contraceptives from the clinics — is well known to this Subcommittee and to Congress as a whole, and I will not belabor the subject. Suffice it to say that four federal courts have found mandatory parental involvement in the provision of family planning services to adolescents to be contrary to the intent of Congress as expressed throughout the thirteen year existence of the Title X program and therefore struck down the parental notification regulations as illegal. The rulings of the courts also made it clear that, illegal or not, such regulations are bad public policy because of the damage to young lives and to families they would cause. The record of comments on the "squeal rule" and the documents provided to the courts demonstrate that potential damage to be very real indeed.

But the fact that the family planning community as represented by the plaintiffs in the "squeal rule" litigation — NFPRHA, Planned Parenthood Federation of America, the States of New York and South Carolina, family planning agencies and others — opposes mandatory parental involvement in the delivery of family planning services to adolescents, does not mean that Title X providers erect "Berlin Walls" when helping adolescents or that Title X providers are not most desirous of family involvement in the area of adolescent sexuality. Quite the contrary.

In March of 1981, NFPRHA adopted the following policy statement regarding the issue of parental involvement in the decisions of adolescents to seek family planning services and counseling. As the statement indicates, NFPRHA and its members feel that parental involvement and support in these decisions is extremely important and ought to be encouraged, but that it cannot and should not be made a requirement for the receipt of family planning services by a teenager. This policy is identical to that adopted by the Congress throughout its deliberations on Title X and was embodied in the 1981 amendment to the Title X statute which called for family involvement in family planning programs to be encouraged, but not mandated, by Title X providers.

> The National Family Planning and Reproductive Health Association firmly supports the unrestricted right of every individual to receive all family planning and reproductive health care services allowable under law and consistent with good medical practice. We just as firmly believe that, in the case of minors seeking these services, the support and involvement of their parents should be encouraged. However, the health and well-being — physical and psychological — of the adolescent must be of paramount concern to providers of family planning services and counseling. Thus, the receipt of services and counsel must not be made contingent upon parental notification, consent or consultation.

Implementation of this broad policy of encouraging but not mandating parental/family involvement has successfully occurred throughout the family planning community. Family planning programs funded under Title X have consistently worked to ensure that intrafamily communication is enhanced when adolescents seek their services, while at the same time remaining aware that the provision of confidential medical services is a basic component of any good health care provider.

The programs of the Council of which I am Executive Director are a good example of the activities undertaken by Title X providers throughout the United States. Throughout the Council's existence, there has been a commitment to encourage family involvement. That commitment's most recent embodiment is the policy adopted by the Board of Directors on February 23 of this year:

FAMILY INVOLVEMENT POLICY

> The Family Planning Council of Southeastern Pennsylvania supports the belief that families have the primary influence and responsibility for educating their children and adolescents about family values, sexuality, and interpersonal relationships. The Council also recognizes that there is a great diversity among families in their values, patterns of communication, and knowledge of human reproduction.
>
> Therefore, consistent with the mission of the Council, the Board of Directors endorses and supports activities of the Council

staff and delegate agencies to assure that families have the resources to fulfill this responsibility. Specifically, the Council supports the following activities:

- o community education programs to educate parents on how to transmit values of family life and sexual responsibility;
- o programs to educate parents and family members to improve communication with their adolescents on contraceptive and other health care issues;
- o clinical care which encourages adolescents to involve their parents and families in their health care; and
- o agency policies which assure that staff are available to parents to discuss their concerns.

The Council will support these efforts, to the extent possible, through funding of programs, staff training, and consultation in program development.

The Council has successfully utilized its programmatic interrelationship of service provision, training and research to foster family involvement and communication regarding human sexuality and birth control. While we are larger than many other Title X providers, similar programs (perhaps on a smaller scale) are the rule rather than the exception at Title X agencies throughout the country.

The Council's innovative and challenging projects in the area of family involvement include the following:

1) The Kinship Project (funded by the DHHS Office of Family Planning in 1979) was a service demonstration project to evaluate the impact of family involvement on adolescents' use of contraceptives and family planning services. Several major papers were published, one of which examined the influence of mothers on adolescent contraceptive use. Another paper in

draft form examines the impact of family involvement counseling services on adolescent use of the clinic and contraceptive methods.

2) Family Involvement Workbook. Under a Title X service delivery improvement grant a workbook for family planning providers has been prepared and covers a variety of topics relevant to planning and implementing family involvement programs.
3) Assessment of Familys' Needs. A paper was prepared and presented at the DHHS Region III Virginia Beach meeting of family planning providers which detailed implications for family planning agencies based on surveys conducted by the Council research staff.
4) Mother/Daughter Study. A paper was prepared which examined the extent of consensus between how adolescents and their mothers perceive the extent and intent of their sex-related discussions.
5) NFPRHA Survey. A survey of over 300 family planning providers was conducted in the summer of 1981. A paper was published, revealing that a majority of providers had been offering family involvement programs for several years prior to the survey.
6) "Let's Talk" Survey. The Council's research staff have consulted with the Philadelphia Youth Service Coordinating Office in a citywide phone survey of Philadelphia residents about the public attitudes and awareness of adolescent pregnancy. A major emphasis in the survey and the city-wide

information campaign is placed on parental responsibility for the sex education of offspring.

7) Each year, several family involvement courses are offered through our regional training program. These are geared to administrators who need to learn how to develop agency-wide support for family involvement, for counselors who need to work with adolescents and parents, for educators who are providing parent/teen communication workshops, and for outreach workers who are recruiting parents of pre-adolescents for sex education programs.

8) During fiscal year 1983, the Council's training department implemented a national contract to develop a family involvement training curriculum. A model curriculum for family planning program administrators was pilot-tested in five DHHS regions and is available to family planning programs.

9) During fiscal year 1984, the training department produced a chapter entitled "Family Involvement" for a manual produced in DHHS Region VII.

10) In fiscal year 1985, the training department will be producing a manual for the orientation of Boards of Directors which will include a segment on developing family involvement policies.

11) The direct service providers of the Council also have developed special initiatives to reach parents. The CHOICE Hotline targets advertising to parents who are directly involved with adolescents. CHOICE also manages the "It's a

Fact of Life" educational exhibit for parents of young children. Other outstanding examples of family involvement include Spectrum Health Services' parent/ adolescent discussion groups, the "Parents: Yes You Can!" program of Planned Parenthood of Bucks County; the paraprofessional counseling program at Temple University where trained volunteers meet with parents and teens in their homes; and the Mother/Daughter program of Planned Parenthood of Southeastern Pennsylvania where teenagers and their mothers join in medical and counseling sessions.

In 1981, more than 4.5 million women received family planning services through federally supported family planning clinics nationwide. The Family Planning Council of Southeastern Pennsylvania is representative of the Title X community in its client population profile.

Below is a breakdown of the client population of the Council for fiscal year 1983; the same percentages are expected to hold for this current fiscal year.

Age	Patients	%
17 & Under	13,453	15.4
18-19	14,809	16.9
20-24	30,899	35.3
25-29	17,199	19.7
30-34	7,098	8.1
35-39	2,560	2.9
40+	1,488	1.7
TOTAL	87,506	100.0

It is important to note that, as these figures demonstrate, only about 15 percent of the patients served by the council and by Title X agencies throughout the country are teenagers under the age of eighteen. Eighty-five percent of our patients are adult women. Thus, it is clear that all the attention of public officials and the general citizenry on this program's services is misplaced when the emphasis of that attention is on teenagers. While our services are exceedingly important for adolescents, this is a program that predominantly serves adults. Therefore, it ought not be administered in conjunction with programs serving only adolescents or have its operations defined by the needs of teenagers.

The racial/ethnic profile of the Council's client population is: 36.5 percent White, 58.4 percent Black, and 5.1 percent Asian, unknown or other. Approximately 3.3 percent of the clients are of Hispanic origin.

The accomplishments of the Title X program have been substantial over its fourteen year existence. Among low-income persons, there has been a marked increase in the use of effective contraceptive methods, virtually eliminating previous differences in method use between the poor and the more affluent.

In 1981, more than 800,000 unintended pregnancies, over half among teenagers, were averted as a direct result of the Title X program. Had these unintended pregnancies actually occurred, there would have been an estimated 282,000 additional births and 433,000 additional abortions that year, with the remaining pregnancies terminating in miscarriages. In its first decade, this program averted a total of 5.4 million unintended pregnancies, including 2.3 million births, 2.5 million abortions and 600,000 miscarriages.

The cost-effectiveness of the Title X program is unchallenged among health and social service programs. Each dollar invested in family planning in one year results in a $2.00 saving the following year in related health and welfare costs resulting from unintended births. The dollar savings is even higher for teenagers, with $2.90 saved for every dollar spent. This increased savings is due to the fact that teenage pregnancies and births are more likely to be difficult and costly, and teenage parents are more likely than adult parents to require welfare or other public benefits.

The national family planning program has from its inception received strong bipartisan support from the Congress and across the land because of its extreme importance as a primary preventive health care services program. Indeed, in July of 1970 the Republican administration stated its support for family planning when President Richard M. Nixon stated, "It is my view that no American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them. This we have the capacity to do."

Unfortunately, the commitment by the Republican administration of the early seventies to ensuring access to family planning services for the nation's low-income women and teenagers — a commitment shared by each successive administration of either party — has been reversed by the Republican administration of the eighties as indicated by the policies and pronouncements of the Reagan administration. That reversal is best exemplified by President Reagan's statement in a letter of July 1981 to Senator Orrin G. Hatch concerning the successful reauthorization of the Title X program in 1981: "I regret that we do not have the votes to defeat the family planning program."

The Reagan administration has consistently sought to repeal the Title X program for ideological and political reasons, and failing that, to significantly reduce the program's funding and undertake administrative harassment designed to destroy the integrity of the national family planning program and render it ineffective and incapable of providing needed comprehensive and Congressionally-mandated services.

In 1981, 1982, 1983 and again in 1984, the administration proposed to repeal Title X as a categorical grant program and place it in a block grant. Congress has consistently recognized that family planning is a national need which transcends state, county and local borders. It agreed with NFPRHA and other supporters of the family planning program that the high incidence of teenage sexual activity, of venereal disease, of unplanned births, of adolescent pregnancy, and of abortions across the country will be brought under control only with a national effort. Congress concurred that strong federal support and direction are required to assure that every person seeking family planning services receives high quality, comprehensive and competent care, no matter in what state or locality he or she resides. Thus, Congress has three times rejected, and we hope and expect it to reject for a fourth time, the administration's misguided primary care block grant proposal for family planning.

In 1981, unable to convince the Congress to repeal Title X, the Reagan administration sought a 23 percent reduction in Title X funding from the level authorized for fiscal year 1982 while seeking only a 12 percent reduction for all other health services programs. Congress wisely rejected the administration's efforts and did not discriminate against Title X when settling on an across-the-board 4 percent domestic spending reduction, thereby providing Title X an appropriation for fiscal year 1982 of $124.8 million. For fiscal year

1983, Congress and the administration agreed to a spending "freeze" for domestic programs, resulting in a fiscal year 1983 appropriation for the categorical Title X program of $124 million. Thus, for two years family planning agencies operated on budgets reduced on average by almost one quarter from fiscal year 1981. Such a reduction had a drastic deleterious effect on family planning agencies and the people they serve.

For fiscal year 1984, the Congress increased the Title X appropriation over the administration's objections by $16 million, or 12.8 percent. Congress made it clear that this increase in funding was to be used to help offset the past two years' reductions in Title X service delivery monies. Yet, under the regional allocation formula imposed by DHHS' Office of Population Affairs (OPA), not only did the ten DHHS regions not receive an equitable 12-13 percent increase in their service delivery funds, but Region I received a 2 percent decrease from fiscal year 1983 and Region II received a 1 percent decrease. The remaining regions received increases ranging from 7.1 percent to 16.5 percent.

Compounding the problem, and ensuring outrage from service delivery providers who have had to struggle extremely hard to continue to provide high quality family planning services in the face of draconian budget cuts, OPA arbitrarily set aside $5 million ($500,000 per region) for special "projects of national priority" — family involvement of Title X adolescent clients, infertility services, natural family planning services, male involvement, and other regionally identified areas of concern. Although the administration has claimed that Title X providers at regional meetings around the country requested assistance in these areas, none of the participants in those meetings with whom I have been in contact agrees with the administration. In fact, many Title X providers — including participants in the regional meetings with DHHS officials — have formally protested the set-aside.

While NFPRHA agrees that special services must be developed and ongoing services improved in order to expand and improve the delivery of family planning health care, we believe that it is essential in the face of massive budget reductions that basic family planning and contraceptive services be adequately funded before DHHS starts setting aside large sums for new initiatives which Congress has otherwise directed be used for direct family planning services.

That DHHS has disregarded Congress' intent regarding the increase in fiscal year 1984 appropriations comes, unfortunately, as no surprise. The goal of the Family Planning Council of Southeastern Pennsylvania and NFPRHA and its members is to continue to play an active role in helping families improve their lives, strengthen their bonds, achieve upward economic and social mobility and reduce the need for social welfare services. Federal support and the commitment of government leaders is essential to the achievement of this goal.

Yet, support and commitment are the exact opposite of the current administration's position regarding the family planning program. For over three years, the Reagan administration has attempted to augment its budget cuts with harassment by audits, personnel and organizational transfers, and untenable and illegal policy changes.

The administration's promulgation of the "squeal rule" was a significant violation of the directions of Congress, as I discussed earlier. More recently, this administration has blatantly defied Congress by refusing to obey directions contained in P.L. 98-139 that DHHS return the administration of Title X to the Health Resources and Services Administration from its current location in the Office of the Assistant Secretary for Health. By so refusing to comply with the instructions of Congress, the administration has decided to retain the administration of the Title X program under the direct control of a political appointee without any professional knowledge or expertise in the administration of a major health care delivery program, Deputy Assistant Secretary for Population Affairs Marjory E. Mecklenburg.

An unprecedented number of audits of Title X grantees have been undertaken during the past three years, at political instigation, by the DHHS Office of Inspector General and the General Accounting Office. Absolutely no violations of law or regulation were found to have been committed. Yet, despite that finding, the Office of Management and Budget has proposed changes in accounting procedures for non-profit recipients of federal funds to prohibit lobbying and related activities by those recipients. The putatively illegal and unconstitutional changes have been blamed by OMB in large part on "proof" supplied by the GAO audits of Title X agencies — proof that simply does not exist.

DHHS proposed, in direct opposition to explicit Congressional instructions, to abolish the service delivery improvement program which provided essential projects designed to improve the delivery of family planning services, gather and interpret data, and set medical standards, among others. That proposal, generated by political concerns and designed to "de-fund" opponents of the administration's family planning policies, was retracted twice under intense Congressional pressure. However, the administration in fiscal year 1984 was able to re-direct the focus of the service delivery improvement program in such a way as to support projects of a type different than that which Congress originally intended.

In a further draconian attempt to resolve a misperception about the operation of Title X agencies and their relationship to abortion services, DHHS proposed new Title X guidelines that would have severed family planning providers from projects providing abortion services at high costs to family planning providers and their patients. This new policy was drafted despite the repeated GAO and IG audits which have found that family planning agencies are scrupulous about obeying the strictures in the Title X statute and regulations against the use of Title X funds for abortion services.

As I noted earlier, all Title X projects explicitly follow the provisions of Section 1008 regarding advocating, promoting or providing abortions with their Title X funds. Yet, because of the misperception by the administration that Title X providers also provide abortions — albeit, perhaps, with private funds — this draft guideline was prepared. But according to DHHS' own figures, of the approximately 5,000 family planning clinics in the United States which received Title X funds in 1981, only 74 perform abortions — 44 hospitals, 21 Planned Parenthood affiliates and nine other private clinics. Although such a policy, if it had not been blocked by significant public and Congressional outcry, would have directly affected less than one percent of all Title X clinics, it was seen as the first step in an effort to block Title X funding to agencies involved in abortion or abortion-related services with private, non-federal funds. Denial of government funding to these agencies is supported by family planning opponents who believe that such funding constitutes government promotion or sanction of abortion. If such a policy is ever adopted, it would deny access to family planning services to low-income women receiving their general medical care from providers who also provide abortions with non-federal funds; conflict with federal court rulings against government attempts to deny funds to organizations because of their exercise of their constitutional rights with non-government funds; ignore the rights of patients to make informed decisions as to their own care; conflict with professional and ethical standards of health care which require that all options be provided to a pregnant woman; and conflict with the laws and policies of a number of state governments which provide payment for abortion services with their own funds.

Finally, the administration has interfered with the competent delivery of family planning services by niggling harassment. The Office of Population Affairs has developed a bunker mentality concerning the national network of family planning providers with whom it is supposed to work. This bunker mentality has emerged following the repeated failures of DHHS to implement its major policy changes. Thus, the OPA staff refuses to return telephone calls or respond to correspondence from those family planning providers and national organizations it dislikes; draft allocation formulas are submitted to the regions for comment too late for input from either regional DHHS officials or grantees or delegate agencies; requests for proposals for family planning grants and contracts are published in the Federal Register late, thereby creating major financial problems for grantees and contractors; funding decisions are influenced by political and philosophical considerations; meetings are held where no information is provided and which are later misrepresented to Congress and others; extraordinary paperwork and reporting requirements are imposed that are simply "make-work" projects that neither reveal new information nor assist in the improvement of the overall program, etc. While it is true that this niggling harassment does not in itself harm the Title X program and provider agencies in a drastic way, it serves to divert the attention of Title X program managers away from thinking of better ways to provide services to patients and toward thinking of better ways to survive in a hostile management environment.

Mr. Chairman, the National Family Planning and Reproductive Health Association recently held its twelfth annual meeting, the theme of which was "1984: Renewing the Commitment." Renewing the commitment did not simply stand for fighting for the right to access to family planning services in the legislatures, in the courts and in the political battles of this country. It also stands for renewing the commitment expressed by President Nixon in 1970 to the delivery of high-quality, comprehensive medical care, counseling and educational services. We urge you and your Congressional colleagues to renew the nation's commitment to family planning and reproductive health care by reauthorizing the Title X statute in 1984 without any debilitating amendments.

Thank you very much.

Attachment
Guidelines of the Family
Planning Council of South-
eastern Pennsylvania, Inc.

GUIDELINES FOR PREGNANCY OPTIONS COUNSELING

Background

These guidelines have been developed to clarify Section 1008 of Title X of the Public Health Service Act which states "None of the Funds appropriated under this Title shall be used in programs where abortion is a method of family planning."

Federal officials have interpreted Section 1008 to prohibit active involvement by staff supported from Title X funds or income related to Title X in providing, promoting or advocating abortion. More specifically, staff in family planning clinics counseling a client with a positive pregnancy test have a responsibility to provide information on all options but not to direct the client in reaching a decision. Staff are not permitted to make appointments for abortion or provide transportation to abortion services.

Recently, Pennsylvania has added a restriction (effective February 1, 1982) on the use of Title XX funds for family planning. This restriction states that no Title XX funds "shall be used to provide, promote, or advocate abortions, or to perform abortion counseling."

Therefore, it is important that providers both make available pregnancy testing and options counseling services and clearly delineate these from abortion services, which may not take place within family projects. The following guidelines have been written to address very specific, concrete questions related to these requirements.

Guidelines for Pregnancy Diagnosis and Counseling

The Title X Program Guidelines for Project Grants for Family Planning Services (Section 8.6, "Pregnancy Diagnosis and Counseling") require the following of family planning projects:

Grantees must provide pregnancy diagnosis and counseling to all clients in need of this service. Pregnancy testing is one of the most frequent reasons for an initial visit to the family planning facility, particularly by adolescents. It is therefore important to use this occasion as an entry point for providing education and counseling about family planning.

Pregnancy cannot be accurately diagnosed and staged through laboratory testing alone. Pregnancy diagnosis consists of a history, pregnancy test, and physical assessment, including pelvic examination. Projects providing pregnancy testing on-site should have available at least one test of high specificity and one of high sensitivity.

If the medical examination cannot be performed in conjunction with laboratory testing, the client must be counseled as to the importance of receiving a physical assessment as soon as possible, preferably within 15 days. This can be done on-site, by a provider selected by the client, or by a provider to which the client has been referred by the project. For those clients with positive pregnancy test results who elect to continue the pregnancy, the examination may be deferred, but should be performed within 30 days. For clients with a negative pregnancy diagnosis, the cause of delayed menses should be investigated. If ectopic pregnancy is suspected, the client must be referred for immediate diagnosis and therapy.

Pregnant women should be offered information and counseling regarding their pregnancies. Those requesting information on options for the management of an unintended pregnancy are to be given non-directive counseling on the following alternative courses of action, and referral upon request:

- Prenatal care and delivery
- Infant care, foster care, or adoption
- Pregnancy termination

Clients planning to carry their pregnancies to term should be given information about good health practices during early pregnancy, especially those which serve to protect the fetus during the first months (e.g. good nutrition, avoidance of smoking, drugs, and exposure to x-rays) and referral for prenatal care.

Clients who are found not to be pregnant should be given information about the availability of contraceptive and infertility services.

In addition to these Title X guidelines, the Council recommends that the following policies and procedures be followed by its Providers in delivering pregnancy testing and counseling services.

Personnel Suitable for Pregnancy Options Counseling

Agencies are responsible for assuring that the staff who provide pregnancy options counseling include physicians, nurses, social workers and counselors who have the following skills and knowledge:

1. ability to establish a relationship with a woman (and a friend/partner/parent) in order that she can explore her feelings about the pregnancy, the results of the pregnancy test, and her alternatives for decision-making.
2. ability to help the woman clarify her feelings and examine the advantages and disadvantages of each of the alternatives so that she can reach an informed decision.

3. ability to provide accurate information about pregnancy tests, pregnancy, prenatal care, adoption, abortion, infertility services, and contraception, as appropriate. This information must include thorough knowledge of medical risks, legal requirements, available resources, cost of services, available insurance coverage or other support, procedures for obtaining services.

4. ability to help the woman implement her decision by providing appropriate referrals.

Availability of Counseling

Face-to-face counseling must be available at the time the test results are given. For clients who desire to receive their results by phone, person-to-person counseling should be available at the time the blood or urine is taken.

Pregnancy options counseling may be offered without testing if the woman brings written results of a positive pregnancy test done elsewhere. Women who have used home pregnancy tests should have another test done at the clinic.

Laboratory Tests

Any laboratory test or procedure which is routine for family planning patients (e.g. pap test, gonorrhea culture, rubella titer) may be offered to pregnancy testing patients. Other tests and procedures specific to pre-natal or abortion services (e.g. blood type, laminaria insertion) are not to be done within the family planning project.

If the test is negative:

1. Give the client the test result clearly and objectively. Do not assume that you know her reaction.

2. Explore the client's feelings about the result.

3. Define limitations of the test. Discuss the need for a follow-up appointment if the onset of menses has not occurred within two weeks.

4. Explore menstrual history and possible causes of delayed menses.

5. A woman who has missed two periods and has a negative test should be evaluated by the clinician for possible ectopic pregnancy or serious underlying condition.

6. If appropriate, discuss contraception, follow-up gynecological care, or infertility services.
7. Complete counseling notes and relevant forms.

If the test is positive:

1. Give the client the test result clearly and objectively. Do not assume the client's reaction.
2. Explore the client's feelings about the pregnancy.
3. As appropriate, explore relationships with partner, family, friends and the support they provide. Encourage adolescents to discuss the pregnancy with their parents.
4. Explore with her all available options - prenatal care and delivery, adoption, foster care, abortion. Help the client think about the health, social, and economic consequences of each option. If the pregnancy appears to be a problem, it is important to introduce all options even if she does not mention each one.
5. Be sure to discuss the timeable for further decision-making. Stress the importance of early prenatal care and/or obtaining an abortion procedure during the first trimester.
6. If the client remains undecided, offer her the opportunity to return for further counseling. Discuss the possibility of her bringing in her partner, a friend or family member if she has not already done so.
7. As appropriate, briefly explain prenatal care and delivery and/or an abortion procedure and any pertinent clinical information.
8. Make appropriate written referrals to sources. The client should be given sufficient information to make her own appointment. Staff may not make appointments for abortions on time paid for by the family planning grant.
9. If indicated, discuss financial resources for her implementing her decision.
10. If appropriate, discuss contraception and plans for contraceptive care.
11. Complete counseling notes and relevant forms.
12. Follow-up on most referrals can be made at the next visit. Counselors should consider telephone follow-up with clients who are extremely anxious, severely

depressed, a victim of abuse, and in other cases where additional support in completing the referral would be useful.

Documentation in Client's Record

Pregnancy test and counseling notes are a part of the client's permanent record. They can be subpoenaed by a court and can be read by the patient if she so requests. Therefore, they should be brief, professional in tone, and without judgements, inferences, or interpretations. They should include the following:

1. LMP
2. Symptoms of pregnancy
3. Contraceptive use
4. Results of test, type of test
5. Options discussed
6. Plan of action, including names of referrals

Senator DENTON. Thank you very much, Mrs. Mann.

Respecting the success of NRPRHA and the abortion part of the question, in fiscal year 1983, your own council's 17 delegate agencies provided 12,354 individual counseling sessions on pregnancy options. According to the pregnancy option guidelines you have submitted for the record, your delegate agencies must keep a permanent record of the counseling notes, including the plan of action taken and the names of referrals made.

How many of the 12,354 sessions conducted last year ended in the decision to abort, and how many referrals were made to abortion providers?

Mrs. MANN. I would say that approximately one-third of those decisions were made to have an abortion. But frankly, Senator, that decision is generally not made in the clinic. What we provide to the patient, as you will see from some of those books, are her alternatives, and we give her the names and addresses of three places from which she can obtain either prenatal care or abortion services. We, at that point, very rarely know, unless that patient comes back to us following the outcome either of the abortion or the delivery of her baby, exactly where she went. We do not follow the patient beyond that point under title X.

Senator DENTON. How many of your title X delegate agencies also perform abortions on the same premises, and what was the total number of abortions performed at those sites?

Mrs. MANN. Well, you would have to define for me what you mean by "the same premises." For example, in a teaching hospital in the city of Philadelphia, do you mean that in that hospital, abortions are provided, and family planning is provided, or do you mean in the same physical location? It is not clear to me what you mean.

Senator DENTON. Yes, to both of your questions.

Mrs. MANN. I have no idea how many abortions were provided by the hospitals in the city of Philadelphia or in the city of Philadelphia, the one Planned Parenthood that provides abortion services. It is not a record of which I keep track. I am interested in how many family planning patients they serve. But in the city of Philadelphia, all of the teaching hospitals that we fund, six of them, as well as the Planned Parenthood, provide abortion services.

Senator DENTON. You mentioned that, in your view, not many of the decisions regarding abortion were made in the clinic itself. I have here a pamphlet from the Planned Parenthood of Southeastern Pennsylvania group, which is one of your delegates, and in their section entitled "Our Philosophy," they allow as follows, in three points: "One, Planned Parenthood believes every child should be wanted, cared for and loved."

Mrs. MANN. Wouldn't you agree with that?

Senator DENTON. Yes, ma'am, but it is also the opening sentence for justifying abortion.

"Two, Planned Parenthood believes that decisions about human reproduction should be a matter of individual conscience."

Mrs. MANN. Would you not agree with that?

Senator DENTON. Again, I believe that decisions about human reproduction refer to the right to choose, because it is the woman's body, an abortion.

"Three, Planned Parenthood is committed to providing accurate and thorough information and services, free from judgment or pressure."

Mrs. MANN. Wouldn't you think that is a good idea?

Senator DENTON. I say, in my view, that, combined with what else you have here, in terms of what happens, would——

Mrs. MANN. That pamphlet was not produced with title X funds. It is not what I have. I do not run that agency.

Senator DENTON. I have learned long ago, I cannot separate out how many pennies go to produce this pamphlet and so on——

Mrs. MANN. I can.

Senator DENTON [continuing]. But I do know that you said that that decision was not made in that center, and I am saying that what is written here is proabortion.

Mrs. MANN. The corporation that I contract with is Planned Parenthood of Southeastern Pennsylvania. I contract with that organization to provide family planning services to 21,000 individuals. That is my contractual relationship; that is title X's contractual relationship with that organization—just as I contract with the University of Pennsylvania, with the city health department of Philadelphia, with community health centers. I have a contractual relationship for part of the business that those organizations are in. I am not responsible for what the entire University of Pennsylvania does in all of its facets.

I contract with Planned Parenthood of Southeastern Pennsylvania to use public dollars for a specific purpose. That is for the provision of family planning services to those in need in the community.

I would like to add one thing that is not in that pamphlet. I do not know that when Mr. Moor was visiting Planned Parenthood, he got any information on their mother/daughter program. Planned Parenthood of Southeastern Pennsylvania has instituted a Saturday morning program and asks teenagers when they call for an appointment if they would like to bring their mothers with them to the clinic. Those that say yes are scheduled to come on Saturday, and a special service is provided for them, which brings the mother and daughter to the family planning clinic together. The program is, I must admit, very successful. Unfortunately, I wish I had had the public dollars to fund it. Planned Parenthood had to go into the community to seek private dollars to fund that program. It was an excellent idea, and I wish I had had the resources to support it.

Senator DENTON. Do you know how many of the 2,000 abortions performed at that site, 1220 Sansom Street, in Philadelphia, one of your delegate title X agencies, do you know how many of the 2,400 abortions performed at that site in 1982 were performed on patients referred to that clinic after receiving pregnancy options counseling from that or any other title X grantee?

Mrs. MANN. No; Senator, I do not keep track of the abortion services of Planned Parenthood. I keep track of their family planning services. That is what I contract with them to provide. Title X provides services for family planning patients. I can tell you a lot about their family planning services. I do not know anything about their abortion services. I do not keep track of them. It is not the business I am in.

Senator DENTON. Well, I do not know what your responsibilities are, and I do not presume to be identifying them with respect to these delegate members, but I did hear you say that you did not think they made decisions about abortion in there, and I read that which is alleged to be a pamphlet which comes from them, which appears to me, and I believe to any other observer, something that pushes abortion as the solution to pregnancy.

Mrs. MANN. I would certainly hope they were not pushing abortion. I would offer you our guidelines and evidence of other programs that really are not pushing abortion, pushing adoption, pushing people to have babies and keep them. We are trying to explain to patients what their choices are and what the reality of each of those choices is for them as a person.

Senator DENTON. I would think that you would be interested in how many abortions were performed at that site after pregnancy option counseling. It would be some kind of indication of what sort of impression one got from the options counseling at those centers. I know that I am very interested in it.

Mrs. MANN. I should add, what we do is that when we do medical audits and program reviews of our agencies, we sit in on counseling sessions, we check their medical charts as per our guidelines. I can tell you what happens on the family planning side of these services. That, I know a great deal about. I know that programs are providing options counseling. I know what information is given to the patients in those programs. What I cannot tell you is the specific, detailed statistics about their abortion services. My, and title X's, interest in this program ends for the pregnant patient once she has received her options counseling.

Senator DENTON. You know, I asked Dr. Brandt a number of questions about whether it was OK or not OK to do this or that with respect to abortion, so I would expect that you would be interested in what that is, because——

Mrs. MANN. Oh, I am in terms of the title X guidelines.

Senator DENTON [continuing]. It is sure going to catch up with you if you are not.

Mrs. MANN. I think Dr. Brandt did quite well. I was listening to you and answering them in my own mind. As far as the title X regulations, I am very concerned about those, and it is my responsibility to see to it that all my agencies are in compliance with the title X regulations, with not just the letter of the law, but its spirit, as well.

Senator DENTON. I thought you were emphasizing something about the family planning side, but not being particularly knowledgeable or concerned about the abortion counseling part of it, and by law, we are concerned about it, because it is regulated by the rules.

Mrs. MANN. I think options counseling is included and regulated by the rules, and I am very concerned with that.

Senator DENTON. And we are trying to see the results of that options counseling and to make inductive conclusions about that.

In the pregnancy options guidelines that you have established for your family planning counseling, it is stated that, "Staff may not make appointments for abortions by the family planning grant." Can an options counselor at Planned Parenthood of Southeastern Pennsylvania, or any other delegate agency, allocate his or her time spent in making a referral during a counseling session to other sources of funding?

Mrs. MANN. The answer is a partial, yes and partial, no. For example, in a hospital, we frequently have social workers who are involved in multiple programs, providing social services to patients of that hospital. If a social worker is employed half-time in the Family Planning Program because she is in the clinic, seeing the patients half of the time, and in another part of the time of her job, she is doing something else that she is employed by the hospital to do, I cannot regulate her other activities, because she is employed by the hospital or the university to do something else. I have no authority over that. It is clear that the only authority I have is over that individual counselor's time when she is working in the Family Planning Program. I cannot write guidelines that regulate the rest of her job. That is not my responsibility.

Senator DENTON. Well, regarding the funds and so on, HHS general counsel has stated that:

> A mere technical allocation of funds attributing Federal dollars to non-abortion activities and other dollars to abortion activities, in what is otherwise a discreet project for providing abortion services, would not be a legally supportable avoidance of the Section 1008 prohibition.

And I suppose you are aware——

Mrs. MANN. Yes; that is why I answered your question as I have.

Senator DENTON. With regard to the family involvement question, would you tell us what criteria NFPRHA has established to determine when parents of teenagers should or should not be included in their daughter's decision to seek contraceptives? Are these criteria based on the physicial and psychological and medical histories of each adolescent? How are you assured of any degree of accuracy, based solely upon the perhaps inadequate knowledge of an unemancipated minor?

Mrs. MANN. Well, NFPRHA is a membership organization. What we have are policies, as a national organization, that reflect the views of our members. Our policy is very consistent with the 1981 amendment, which is that it is the teenager's responsibility to talk with her parents about her involvement at the clinic. We certainly support family involvement; we encourage it among our members. We have written and produced several publications, one of which is called "Focus on Families," to help our members, to provide technical assistance to our members in family involvement programs. But as a membership organization, NFPRHA does not have any authority over its members. We can provide guidance to them, such as the book, "Focus on Families," which is a technical guide for the improvement of involving families, and support the 1981 amendment.

Senator **Denton**. I thought we had congressional intent established with words to the effect that family——

Mrs. **Mann**. NFPRHA does not receive title X funds.

Senator **Denton** [continuing]. Family involvement would be encouraged to the maximum extent practicable. Would not that lead to some kind of change in your regulations over that which you had before, to the degree that you do have any control over the activities and attitudes in these delegates which serve under you?

Mrs. **Mann**. Are you asking me—I am looking for some clarification, Senator—are you asking me about my subcontracting agencies, or NFPRHA's membership? I am wearing two hats.

Senator **Denton**. Your subcontracting agencies, as far as you personally are concerned and as far as NFPRHA in general is concerned.

Mrs. **Mann**. Well, as far as our subcontractors are concerned, we have been encouraging family involvement for many years. As early as 1979, we began a demonstration project to attempt to involve and retrain our counselors and work very seriously with our teenage patients and involving their families, and have done some subsequent research about that. That was long before the 1981 amendments. We have been concerned about involving families for some time.

Since the 1981 amendments, and prior to them, we have been working with our agencies. We have a board policy involving family involvement. We have projects of our agencies that have involved families. It is an effort that is constrained only by our resources.

Senator **Denton**. Well, don't you have concerns that the parents coming into the problem will cause harm, psychological damage to the children, and so on, or a decision not to use the contraceptives? You said you are limited only to your resources. I would think it would be very simple to just call the parents up and say, "Mary is in here."

Mrs. **Mann**. Yes. I think what the 1981 amendments clearly say is that to the extent practicable, the teenager should be talking to her parents. Efforts have gone in two major areas. One is to work with, retrain, and continually train our counselors to help teenagers do better in talking with their parents. And we have succeeded. If our data is correct, and I have no reason to think it is not, on the initial visit, 40 percent of our teen patients tell us that their mothers know they are at the clinic. Fifteen months later, when we ask the same question, that number rises to 72 percent of the teenagers tell us—these are teenagers 17 and under—that their mothers know they are at the clinic; that they have told them, in their own way and in their own.

That tells me that our voluntary effort in working with the teenagers who are at our clinic is working. I do not have all the answers on how to make teenagers talk more and in a better way to their parents. But certainly, if the teenagers come to us, we can work with them, and I think we are succeeding.

The other thing that we are doing is working with the parents in the community, to try to make the other side of the equation work. Parents have a responsibility in this to communicate with their teenagers, with their young children, and so we work with parents in the community—in the churches, in the community centers, wherever we can.

The other thing that we are trying to do is to work with the patients who come to us, the vast majority of adult, low-income women, who have children, or are planning a family, to talk with them, in a really preventive way, about how to begin to talk to their young children. We have an exhibit, we have books, we have pamphlets. We have trained our counselors. It is not enough to talk to the teenagers; that, we do. It is almost more important to begin to work with the parents who are coming to us for family planning services as adults and help them talk to their young children. Communication about sexuality cannot begin in the teenage years. It has to be done throughout the growth and the development of the child.

Senator DENTON. Well, we certainly have no problems in those directions that you have just mentioned. As you know, I have tried to establish criteria for reasonable exceptions to parental involvement, and they have included the following: parents who would physically harm the child, abuse the child—not necessarily just spank, but I am talking about real abuse—a court determination that the parents or guardians of an unemancipated minor are unfit or unable to properly care for the minor. We never, in any of the laws or resolutions, nor in any of the proposals I have made, have recommended informing the parents when a child comes in to be tested for venereal disease.

Mrs. MANN. Why is that?

Senator DENTON. Because we would not want in any respect to interfere with that test. I do not want to add any requirements to the test.

I would think that one should add, when you talk about how the parents get involved, 40 percent, 48 percent, 70 percent—what I would like to see the parent involved in is that original decision, when the child comes in there and has not yet committed—or may be willing to uncommit, like Mary Magdalen did. All of us can change—and I think the parent has that right—and you are seeing that scream through the Gallup Poll, but you are going to be seeing it more and more, and not because of Senator Denton, but because the more this is aired, the more you are going to hear the screams, because they do not feel that you are superior to them in judging what should be said to their child.

Mrs. MANN. I am not.

Senator DENTON. We have also eliminated immediate threat to the life of a minor requiring medical or protective intervention, and parents or guardians informing the grantee that they do not want to be involved in the services; any court determination that the parents or guardians of an unemancipated minor are unfit or unable to properly care for the minor. So I am not blanketly going for parental involvement.

Mrs. MANN. May I ask you a question?

Senator DENTON. Yes, ma'am.

Mrs. MANN. Do you think that the 1981—I think I asked you this question when you came to speak to NFPRHA's annual meeting in March—which I appreciated very much; it was very helpful to hear your views——

Senator DENTON. I wish you could see what was said. The people on the left said I made no converts, that everybody in there sort of hated me. The people on the right said, "The conservatives have to take another look at this jerk, because obviously, he is not really a conservative." so it is a real fun thing to deal with.

Mrs. MANN. I am not sure about the former. I think that in your coming to NFPRHA, and in the content of your speech, you made it very clear where you stand. And in most of those areas, we agree with you. We agree with you about the fact that 13-year-olds should not be having sexual intercourse.

I also think that in that presentation, you made it clear that maybe we did not have the answers—the single, one best answer about how to involve families in these decisions. And I would agree with you. I do not have the answer.

But one of the things I would wonder about is whether or not we know whether the 1981 amendment is working, whether it is good enough; whether what we really want is a maximum degree of flexibility and creativity in local communities, to design family involvement programs that work for them. We are trying that across this country, and I think one of the things I wonder about is how well it is working; how well is the 1981 amendment working, before we need to change it or fix it. Maybe it is not broken. Maybe we are doing the best we possible can. And it seems to me that family planning programs and title X programs do need to get some credit for the efforts that they are making at all of these levels.

I do not think that sending a note home is the best way to have family involvement in the decisions and discussions around human sexuality and birth control. I do not think it is the best way. I do not know if you think it is the best way.

Senator DENTON. Well, I do want to be reasonable and objective, as you appear by your tone and your words to be being. I do not claim any monopoly on either virtue or knowledge. I do believe that there are many questions which have not yet been answered, but I must candidly tell you that on balance, in all candor, I believe there is not enough parental involvement right now. I make that a net judgment. I believe that that is a problem right now, and that it is not being solved fast enough. I believe there should be accountability when one interposes oneself between a child and one's parent. I do not see that accountability. I consider that another problem.

So I guess that is about as clear as I can make it for myself.

I want to thank you for your own testimony this morning, and I hope that further examination of these issues can bring us closer to that which is best for the promotion of the general welfare in this country, for the pursuit of happiness on the part of our individual children and their parents; that the preservation of parental rights and authority is looked to; that the act of sexual intercourse, while quite pleasurable, not be portrayed as only recreational, but as involving the act by which a third human being, equally important to the other two, is brought into this world. Were all of that being presented, I would feel a lot more comfortable. From what I have seen, it is not. It is being presented aggressively, as an amoral question—and when I say "amoral," I am talking about the compassion and the love for another human being, consideration for another human being, namely, the unborn, which might be conceived or born as a result of that act.

Mrs. **Mann**. May I have 1 more minute?

Senator **Denton**. Thank you.

Mrs. **Mann**. I appreciate it.

I think that families have a responsibility to communicate their moral values to their children. I do it as a mother. I think that your responsibility is in the home. Moral values come to children primarily from their families.

Senator **Denton**. Dorothy, at that point, let me ask you this, because I have heard the doctors and everybody else say this, that the families are failing. The families are trying to hack television, Hollywood, the song lyrics, and everything that is going on at school with drugs and peer pressure. They are under pressure. Are you helping parents or not, by not letting them have another chance with their child?

Mrs. **Mann**. I think we are helping them, because most parents wish that they had more control over teenagers, in a variety of ways. It is one of the stages of life that is the most difficult to deal with as a parent. We do not necessarily control these kids. They are off on their own, doing a lot of things. Sometimes, the best we can do is guide them. Sometimes, the best we can do is trust that we have communicated our moral values to them as they have developed as children.

The Family Planning Program does not control these kids, either, no more and no less than families do. We see them a few hours a year. We do the best we can in getting them back together with their families, because they continue to trust us.

Senator **Denton**. Well, if you want to come up to the office, I will show you some materials, and then ask you person-to-person whether you think as a parent that that is what you would have wanted to be presented to your child by a government grantee, spending your tax money, and then we will have had a complete discussion.

Mrs. **Mann**. If you will let me share with you the materials that I have.

Senator **Denton**. I would be delighted.

Mrs. **Mann**. Wonderful. Can we have a date?

Senator **Denton**. Yes; any time we can find the time, which I hope is today.

Mrs. **Mann**. Thank you, Senator.

Senator **Denton**. Next, Dr. Joan Babbott--and I apologize very much, Dr. Babbott. She is the executive director of the Planned

Parenthood League of Connecticut and is testifying on behalf of Mrs. Faye Wattleton, the president of the Planned Parenthood Federation of America.

I want to welcome Dr. Babbott. She has been very patient. We had Planned Parenthood on first in most of our hearings. This time, they are coming on last, in the interest of trying to balance things.

You may proceed any time, Dr. Babbott, with your statement.

STATEMENT OF JOAN BABBOTT, M.D., EXECUTIVE DIRECTOR, PLANNED PARENTHOOD LEAGUE OF CONNECTICUT, ON BEHALF OF FAYE WATTLETON, PRESIDENT, PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.

Dr. **Babbott**. Thank you, Mr. Chairman.

I am Joan Babbott. I am a physician. I was trained in pediatrics and public health. I am also the executive director for the Planned Parenthood League of Connecticut, a nonprofit, voluntary, health care organization and a major reproductive health provider in Connecticut.

Planned Parenthood of Connecticut is a statewide affiliate of the Planned Parenthood Federation of America, which consists of 191 affiliates in 43 States.

Last year, Planned Parenthood clinics served nearly 2 million men and women, providing information and medical services to enable them to prevent unintended pregnancies and to make informed decisions about having children.

In Connecticut, we saw 43,500 women at our 19 clinic sites. Yet, even when combined with services offered through other clinics, we estimate less than half the need for organized, subsidized services is met.

When title X passed, with broad bipartisan support, the Government committed itself to enabling all individuals to decide the number and spacing of their children. Title X does not serve just women on welfare, nor just the poorest of the poor. Many marginal income and unemployed families depend upon these title X clinics. This is important where the women served are teenagers, since teenagers who become mothers typically have no marketable skills, little education, and no husband capable of supporting a family. A recent Civil Rights Commission report noted that half of the $9.4 billion invested in Aid to Families With Dependent Children in one year, 1975, went to families in which the woman had given birth as a teenager.

About 80 percent of all family planning services provided to teenagers at specialized clinics are in title X programs. Title X is the Nation's major vehicle for preventing unintended adolescent pregnancies. Roughly one-third of the women served were in their teens. The majority of the teenagers served are 18 and 19 years old. Teenagers often delay seeking contraceptives for 1 year or more after they become active sexually. Their first visit to a clinic is commonly to determine whether they are pregnant. And I, as a clinician, have experienced that over and over again. The major reason for this delay is fear that their activities will become known to their parents. Thirty-seven percent of the women seen at

Planned Parenthood of Connecticut are 15 to 19 years old. Most of these are the older teens. Our philosophy is to involve the family in decisions around reproductive health care to the strongest extent possible, while protecting the needed confidentiality.

Eighty percent of the other women served have incomes below 150 percent of the poverty level. Because for many women, we are their sole health provider, our services include in addition to a complete range of contraceptive control for men and women, a careful health interview, breast exam, blood and urine test, blood pressure check, pregnancy testing, and PAP smear. Referral to other health services will be made when circumstances indicate.

Planned Parenthood of Connecticut, with its private donations, offers first trimester abortion at three clinic sites and vasectomy at one site. These services comprise only 2 percent of our services and are not funded through title X. Most title X funds go to State or local health departments.

Planned Parenthood affiliates serve 27 percent of the national caseload.

As a result of the Federal Family Planning Program, more than 800,000 pregnancies, half among teenagers, were averted in 1981 alone. If these pregnancies had occurred, there would have been an estimated 282,000 additional births and 433,000 more abortions. Each dollar invested in family planning saves $2 in health and welfare costs associated with unintended births the following year. The cost/benefit ratio is even higher for teenagers. In 1981, some 9.5 million low-income women in this country were at risk of unintended pregnancy, and only half could obtain services. Because of the failure to obtain services, contraceptive failure or lack of understanding concerning pregnancy, there were nearly 1.6 million abortions in 1982. That is one abortion for every two live births in the United States.

The problem remains a serious one for all women, with the greatest impact felt by the poor and the young, because their needs cannot be met. We encourage the Congress to keep title X a strong, Federal categorical grant program. We recognize the constraints under which you operate, but urge you to authorize more money so that the program can reach those not served.

Planned Parenthood of Connecticut is a direct grantee of title X dollars for Connecticut, which enables us and our six subgrantees to bypass the State bureaucracy, thus allowing more of those dollars to be used for direct services. It also enables us to serve more women by stretching those dollars with private contributions.

In the comprehensive statement, there are recommendations about the administration of the program. We also recommend more support for education programs and contraceptive research.

Quality services, offering the safest and most effective methods, are essential. Unplanned pregnancy is a national problem, demanding a national solution.

We would appreciate your support, Mr. Chairman, in communicating this message to the Congress, and we look forward to working with you in underscoring the importance of preventive, subsidized family planning services for those in need.

[The prepared statement of Dr. Babbott follows:]

TESTIMONY OF
JOAN BABBOTT, M.D.
PRESIDENT
PLANNED PARENTHOOD LEAGUE OF CONNECTICUT
ON BEHALF OF
FAYE WATTLETON
PRESIDENT OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.
BEFORE
THE SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES
OF THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
APRIL 5, 1984

Planned Parenthood Federation of America, Inc.
810 Seventh Avenue New York, New York 10019 212/541-7800

April 5, 1984

Mr. Chairman and Members of the Committee:

I am Joan Babbott, President of Planned Parenthood League of Conneticut on behalf of Faye Wattleton, President of the Planned Parenthood Federation of America (PPFA). On behalf of the more than 18,000 volunteers and staff who run our 191 affiliates in 43 states, the 300,000 individuals who contribute to our organization, and most importantly, the nearly 2 million women and men who are served by our clinics each year, I want to thank you and the subcommittee for holding this hearing. I appreciate the opportunity to present our views on the state of our nation's efforts to reduce the incidence of unintended pregnancy, particularly among the poor and the young.

From our very beginning in 1916, Planned Parenthood has been committed to the principle that every child should come into the world wanted, welcomed and loved. In the mid-1960s, the federal government initiated some tentative efforts through the Office of Economic Opportunity to begin to make this principle a reality for the millions of American women and their families who were unable to avail themselves of voluntary family planning services without help. Then, in 1970, Congress passed and President Richard Nixon signed into law the Family Planning Services and Population Research Act -- now Title X of the Public Health Services Act. The United States government clearly and unequivocally committed itself to enabling all individuals to freely decide the number and the spacing of their children.

From those earliest days of its history, Title X has enjoyed bipartisan support. Democrats and Republicans in both houses of Congress embraced the notion -- and supported the program -- of using government resources to make voluntary family planning available as a tool to enhance the health and welfare of mothers and children, through the prevention of unintended pregnancy.

Members on both sides of the aisle, and on both sides of the abortion question, also embraced federal support for family planning as the single, most direct means available to reduce the need for abortion among women in this country. (One of the early, vocal supporters of the program was a Republican Congressman from Houston, now Vice-President George Bush.)

Given that history, it has been hard to understand the consistent hostility of the current administration to Title X. Each year beginning in 1981, and again this year, the administration has called for the program's repeal. As you know, Mr. Chairman, in 1981 and each year subsequently Congress has rejected the block grant approach in favor of retaining Title X as a federal categorical program.

Rebuffed by the Congress, the administration has worked tirelessly to administratively undermine the program. That is consistent with a letter that President Reagan sent Senator Hatch (R-Utah) in July 1981, lamenting that "we do not have the votes to defeat the family planning program...." "Perhaps we can remedy some of the problems in the family planning program administratively during the three years that it will remain as a categorical grant," the President went on to say. That was a warning of what was to come: three years of non-stop harassment and ill-management of the program by administrators who perceived the "problem" as being the family planning program itself -- and particularly its priority of serving adolescents.

What is Title X?

Title X is the only program through which Congress can affect and monitor the extent to which family planning services are provided around the country;

it provides more than half of all federal funds for services; it serves as the program base from which other sources of support -- state and local -- can be obtained.

Title X authorizes project grants to both public and private nonprofit organizations to provide family planning services (including natural family planning and infertility services) to all who want and need them, but with priority given to low-income persons. No abortions may be provided with Title X funds. The services program is complemented by a training program for clinic personnel, limited community-based education activities and strict evaluation requirements to ensure program accountability. The FY 1984 appropriation for the entire Title X program is $140 million -- well below the $162 million spent on Title X in the last year of the previous authorization.

Title X is the nation's principal vehicle for preventing unintended adolescent pregnancies. Of the 4.6 million women served in organized programs in 1981, approximately one-third were young women in their teens. According to the Department of Health and Human Services (DHHS), about 80 percent of all family planning services provided to teenagers in specialized clinics are in programs supported by Title X.

It is demonstratable that dollars spent for family planning save a great many more dollars in the direct and indirect costs associated with unintended pregnancies. But since Title X services are not limited to the poorest of the poor, nor to women on welfare, Title X also plays an important role in helping marginal-income individuals and families stay off of welfare.

This is particularly important where teenagers are involved. More often than not, teenagers who become pregnant have few marketable skills, too little education and no husband to provide adequate support. According to a 1983 report from the U.S. Commission on Civil Rights entitled "A Growing Crisis, Disadvantaged Women and Their Children," about half of the $9.4 billion invested in the federal Aid to Families with Dependent Children (AFDC) program in 1975 went to families in which the woman had given birth as a teenager. Six out of 10 women in families receiving AFDC payments had given birth as teenagers, compared to just about one-third of women in families not receiving such payments.

Title X is important to the health and well-being of nearly every family in another way which attracts much less public attention. In 1979, the most recent year for which worldwide data have been compiled, it provided explicit legislative authorization for close to 60 percent of total United States funding (including private industry and philanthropic contributions) for research in the reproductive sciences and contraceptive development. And, the United States in turn was responsible for more than 70 percent of all expenditures in the world for such research.

It is well recognized by now that virtually all contraceptive methods currently in use have some serious drawbacks, whether they involve efficacy, safety, or acceptablity. The most effective temporary methods, the pill and the IUD, have side effects (for some) which have been highly publicized. As a result, contraceptive use -- while nearly universal in our society -- is often both imperfect because of existing methods, and because human beings, too, are imperfect. The inadequacy of available contraceptive methods is reflected in the distressingly high rates of recourse to abortion.

While we wait for better contraceptive methods and choices to emerge, there are 36 million American women faced with the everyday problem of how to prevent getting pregnant unintentionally. As I mentioned earlier, 4.6 million women rely on the subsidized family planning clinic system to obtain services. While services to teenagers receive a great deal of attention, it should be emphasized that two-thirds of the patients in this program are adult women. In the early years of the program, many came to the clinics only after they already had all the children they wanted (or more). Today the typical patient does not yet have children. Eight in 10 have incomes below 150 percent of the official poverty level.

The vast majority of the teenagers served are 18 and 19 year-olds. Many teenagers delay seeking contraceptive help for a year or more after initiating sexual activity. Their first contact with a family planning clinic often occurs when they already are -- or think that they are -- pregnant. A major reason for the delay in seeking contraceptive assistance is fear that their sexual activity will become known to their parents.

Agencies that provide Title X services are as varied as the individuals and families they serve. Some 2,500 separate agencies operate clinics at over 5,000 service sites in virtually every county in the country. Most Title X funds go to state or local health departments: Planned Parenthood affiliates served 27 percent of the national caseload; forty percent of the patients were served by health departments; 13 percent by hospital-based programs and the remainder (20 percent) by a variety of other agencies such as HMO's, neighborhood health centers, free clinics, etc.

Approximately $124 million was appropriated in FY 1983 for Title X family planning services. The bulk of that money was awarded to health departments, hospitals and the variety of county agencies just mentioned. Planned Parenthood affiliates received a total of about $30 million, or 24 percent.

I want to stress that Planned Parenthood is a federation of autonomous, local nonprofit agencies which operate with boards and staff from the communities they serve, within federal mandates and guidelines. Since Title X project grants are made only for direct services, each Planned Parenthood affiliate must apply to the government on its own if it wishes to receive Title X support. Grant decisions are made by the DHHS regional offices based on applications from state and local health departments and various "umbrella" agencies. These applications in turn are based on a determination, at the community level, of which agency or combination of agencies is best suited to provide the needed services efficiently and effectively. In most instances, therefore, receipt by Planned Parenthood affiliates of federal funds is conditioned upon community-based decisions. Title X project grant money for services does not support any activities at PPFA headquarters in New York City, nor is PPFA involved in any way with the allocation of Title X funds to its affiliates. (I have attached to this statement material that describes PPFA's structure, objectives, programs and financing.)

Title X-funded family planning clinics provide a variety of health care services and information for men and women. For many women, these clinics are their primary source of health care. Teenagers often enter the adult health care system through a Title X clinic. The contraceptive services funded by Title X comprise a much broader range than most people realize, including education on reproductive health systems and methods of birth control (including natural family planning); a complete health screening assessment; contraceptive supplies with appropriate instruction; and laboratory tests that screen for anemia, hypertension, cervical and breast cancer, sexually transmitted diseases, kidney dysfunction and diabetes. Some family planning clinics also provide the additional services of prenatal care, infertility diagnosis and treatment and sterilization. Counseling is available for all patients, as is instruction pertaining to breast self-examination, pregnancy, human sexuality and nutrition.

What Has Been Accomplished?

As a direct result of the federally funded family planning program in 1981 alone, more than 800,000 unintended pregnancies -- about 425,000 of them among teenagers -- were averted. If these unplanned pregnancies had occurred, there would have been an estimated 282,000 additional births and 433,000 more abortions that year. (The remaining pregnancies would have ended in miscarriages.) During the entire decade of the 1970s, a total of 2.3 million unintended births were averted because of the federally supported family planning program. This has been achieved with a cost-effectiveness unparallelled by any other federal program. Each dollar invested in family planning by the government in any one year yields a saving of $2.00 in health and welfare costs associated with unintended births the following year. For teenagers, the cost/benefit ratio is even higher -- a $2.90 saving for every dollar spent -- because teenage pregnancies and births are more likely to be medically problematic and teenage parents are more likely to need welfare or other public benefits than their adult counterparts.

What Is the Remaining Need for Federally-Subsidized Family Planning Services?

Between 1980 and 1981, the number of low-income women who were at risk of unintended pregnancy rose by about 30 percent, to 9.5 million. This is a direct reflection of the increase in the proportion of women who are poor. Only slightly more than half were able to obtain services. The subsidized clinic system removes the financial barrier that for many is the primary obstacle to receiving needed care. The average first-year private sector cost of using the pill, for example, is $172 including supplies and medical supervision. Not surprisingly, women of limited means often seek cheaper, less reliable contraception or use none at all. Far from having reached a time when the need for services has been met, the demand today is even greater. As a result of the inability to obtain services, contraceptive failure or a simple lack of understanding concerning pregnancy (especially among teenagers), there were approximately 1.6 million abortions in 1982 -- a clear indicator of the remaining problem for all women, with the greatest impact being felt by the poor and the young.

While the states and other federal programs (Medicaid, Maternal and Child Health and Social Services Block Grants) contribute financially to the national family planning program, the categorical, federal Title X program establishes the structure that is necessary for the program's high quality and effectiveness. Under Title X, national medical standards have been developed, there are informed consent protections for the patients, and there is a national reporting system that ensures accountability for federal dollars and facilitates planning for future service needs. Despite the strong support demonstrated by some states, the philosophical and programmatic direction for family planning services stems directly from the existence and reaffirmation of Title X. It is therefore imperative that the federal government which supports family planning as a basic public health service provide clear policy direction by maintaining the integrity of Title X.

The Program and Its Politics Since 1981; PPFA's Concerns and Recommendations

Mr. Chairman, since Title X was last reauthorized under the Omnibus Budget Reconciliation Act of 1981, the program has been intensely scrutinized, subjected to political harassment and administrative confusion and uncertainty. Title X has withstood this array of assaults. It is my hope, Mr. Chairman, that the insidious warfare on Title X that has been ongoing since 1981 will be resolved openly and positively during this year's reauthorization process.

First we had the ill-fated "squeal rule" and the contemplated DHHS guidelines that essentially would have disqualified any agency that provides abortion from receiving Title X funds for family planning services -- both in 1982. Then in 1983 came the sudden transfer of the Office for Family Planning to be administered by a hostile political appointee, isolated from the other primary care and maternal and child health programs in the Health Resources and Services Administration. And now in the face of the renewed call for the abolishment of the program in 1984, Title X has survived.

Along the way, DHHS has attempted to "block grant" the program administratively, by reducing the number of direct grantees from 222 in FY 1981 to 86 in FY 1983, with a strong bias toward state health departments. This bias toward state governments as the "preferred" recipient of direct Title X grants has no basis in the Title X statute, as you well know. Even so, DHHS' consolidation efforts might have been tolerable had it not been carried to an extreme, as in the case of Utah. There, Planned Parenthood of Utah and Park City Community Clinic were suddenly defunded in favor of the state health department -- presumedly to increase administrative efficiency by consolidating three grants into one. In fact, it is clear that the true motive for consolidation was to enable the health department to impose a state parental consent law. Just last month, Federal District Court Judge David K. Winder ruled that this was in direct conflict with the requirements under Title X and the state was deemed ineligible for these funds as long as it defied federal law. Most of the funds have now been redirected to the Utah providers offering services in compliance with Title X: Planned Parenthood Association of Utah and Park City Community Clinic. The acting executive director of the state health department reacted by saying, "We'll try to finesse our way around the ruling...."

Mr. Chairman, despite our deep concerns about the current management of Title X under the Deputy Assistant Secretary for Population Affairs (DASPA), we feel strongly that this position should be retained. Now that DHHS has forced the question by delegating direct program responsibility to the DASPA for the first time in the program's history, however, we believe that the division of responsibilities as originally determined by the Secretary of DHEW in 1970 and continued until January, 1983 was an appropriate one. The Title X program must be run by an experienced public health program manager. At the same time, overall policy and coordination with other DHHS programs complementing Title X (services under Medicaid, maternal and child health, social services, research at the National Institute of Child Health and Human Development, evaluation at the Centers for Disease Control and the Food and Drug Administration) should be orchestrated at a higher level -- the DASPA. While the current DASPA has now been granted the additional task of managing Title X directly, she has not even fulfilled her responsibilities as DASPA. The "feasibility study" that was to examine the ability and willingness of the states to administer and deliver family planning services ordered by Congress in 1981 has yet to appear. The statutorily required "Five Year Plan for Family Planning Services and Population Research" for FY 1982 was finally transmitted to Congress nine months late and is so "streamlined" from previous years' reports as to be of questionable value. And, of course, there are problems on the program management side.

We no longer see much interest, or ability, at DHHS in collecting and analyzing national program data. After terminating its long-standing contract with the Alan Guttmacher Institute last September, DHHS stated in January that it would do in-house those things that the Guttmacher Institute had done. We urge this committee to ensure that DHHS follows through on this promise, since program accountability has at least until now always been reliable and crucial to the program's success. We are skeptical about the department's sincerity, since it is proposing block grant legislation which would eliminate any data collection requirements. We are now convinced that running Title X program operations day-to-day and fulfilling the requirements of the DASPA are too much for one person and one office to handle.

Related to the transfer of the Office for Family Planning is the fact that it has made it more convenient for DHHS to view Title X through the lens of the Adolescent Family Life Act (AFLA), which is being run from the same office. These two programs have entirely different goals, legislative histories, target populations and service delivery systems. Yet, the administration cited the AFLA in its legal defense of its imposing the squeal rule on Title X. We believe it is important that these two independent programs be run as two independent programs.

Mr. Chairman, in 1981, part of the price to pay for continuing family planning (as well as most other domestic programs) was to accept a drastic 22 percent cut in appropriations. This year's appropriation of $140 million is still $22 million below FY 1981's level, not adjusting for inflation. As a result, family planning clinics have not only been fending off all the political attacks on the program's philosophy, but have been struggling under severely strained budgets. DHHS estimates that as many as 1,000 clinic sites have closed since 1982. Numerous special projects have been discontinued, including male involvement and community education, among many others. In order to preserve the core of the program -- medical contraceptive services -- clinics have had to diminish their information and education activities. This has implications not only for teenagers, but adult women in light of the extent of public misinformation that exists about current contraceptive methods. According to the DHHS implementation plan for "Promoting Health/Preventing Disease: Objectives for the Nation," published in the September-October 1983 issue of DHHS's Public Health Reports, "by 1990, at least 75 percent of men and women over the age of 14 should be able to describe accurately the various contraceptive methods, including natural family planning, as well as the relative safety and effectiveness of one method versus the others." We would suggest that to accomplish this, Title X's current section on information and education be expanded and given higher priority.

Mr. Chairman, along with a strengthened service program it is time to focus more attention on the current state of contraceptive technology. I mentioned earlier that tremendous misunderstandings exist about the safety and efficacy of current methods. Fear and ignorance may account in part for why the fourth most common method of birth control is "no method" for more than 3 million women, and why another 3 million use the least effective methods. But this does not take away from the fact that women of different ages and circumstances need different choices that would maximize contraceptive effectiveness and acceptability. For now, most women are making decisions according to the "least bad" theory.

Mr. Chairman, I would like to take just a moment to make note of our special concern about the decline in funding over the last four years for research specifically devoted to the development of better contraceptive methods and the testing of their safety and effectiveness. The research Title X authorizes in both the reproductive sciences and contraceptive development is administered by NIH's National Institute of Child Health and Human Development (NICHD). Research in the reproductive sciences involves basic research in the biology and chemistry of human reproduction, while research in contraceptive development and evaluation is devoted to applying the findings of basic research to the actual development and testing of contraception. In short, all of the work supported in reproductive sciences is meaningless to family planning if it is not applied to the development of improved methods of family planning.

At a time when there is so much public discussion about the incidence of abortion and so much concern about the safety of available methods of contraception, one would expect to find increasing support given to research in contraceptive development and evaluation. In fact, the opposite is occurring. In fiscal 1981, NICHD's support for contraceptive development was $8.254 million; for fiscal 1985, it is requesting $8.180 million. In fiscal 1981, NICHD support for contraceptive evaluation was $4.292 million; for fiscal 1985, it is requesting $3.133 million. Instead of an increase in support for these vital areas of applied research, we are seeing a nine percent reduction in NICHD funding for contraceptive development and a 25 percent reduction in funding for contraceptive evaluation. To put this in perspective, just two years ago, the Office of Technology Assessment recommended an addtional $20 million annually for federal funding for contraceptive development, noting that available research opportunities are only waiting funding to be more fully exploited. We would therefore strongly endorse increasing support specifically for contraceptive development and evaluation to pursue existing leads for new methods and provide reassurance about current ones.

Mr. Chairman, Planned Parenthood's primary mission is to enable all Americans to prevent unwanted or unintended pregnancy so that individual couples can achieve their own family size goals. High quality services offering the safest, most effective and most acceptable methods are essential. Unplanned pregnancy is indeed a national problem demanding a national solution. We look forward to working with this committee now and in the future in sustaining and heightening the importance of preventive, voluntary subsidized family planning services for those in need and the pursuit of better contraceptive technology for all of us, in the United States and around the world.

Senator **Denton**. Thank you, Dr. Babbott.

Senator Weicker very much wanted to be here today to hear your testimony and greet you personally. He is attending to his duties as chairman of the Labor and Human Resources Appropriations Subcommittee.

Dr. Klaus stated that her natural family planning organization does not sell a product which brings a profit to a manufacturer or to them, and the last witness made some remarks about lamenting the fact that the teenagers were 13-year-girls who were sexually active and so on.

I would feel better if I were to read about Planned Parenthood that they were selling pamphlets, suggesting the inadvisability of premarital pregnancy, rather than diversifying into the sale of their own brand of condoms.

Is Planned Parenthood planning to finance their operations through those sales? I have been reading that they were considering selling their own brand of condoms.

Dr. **Babbott**. No; we certainly would never finance all of Planned Parenthood federation's programs through the sale of condoms. However, any income from condoms certainly would enable us, and does enable us, to publish a great many pamphlets. I wish you could see in Connecticut, several of our resource centers, libraries, the kinds of pamphlets, the kinds of materials we do sell and do give out to schools, parents, anyone who wants them, discussing many different ways of contraception. In fact, one very good pamphlet we hand out discusses natural family planning as one of the options.

Senator **Denton**. And then again, on the subject of abortion, we had the Planned Parenthood delegate under Mrs. Mann saying "Planned Parenthood believes every child should be wanted, cared for and loved." I did not comment on that, except to say that I certainly agree with it, but I do believe it introduces some proabortion rationale.

Dr. **Babbott**. I would like to talk to you about that statement.

Senator **Denton**. OK. Let me finish this one brief point. They then say that "Planned Parenthood believes that decisions about human reproduction should be a matter of individual conscience."

I would feel better were Planned Parenthood, again, selling pamphlets which advertise the truth, that there are hundreds of thousands of families, waiting to adopt, who want, would care for and love the child, which otherwise is disposed of through abortion. I do not see much of that in Planned Parenthood's literature.

So you go ahead and address that.

Dr. **Babbott**. I would just reemphasize the fact that I was trained as a pediatrician, and I have been in family planning, women's health, maternal and child health field for about 20 years. One of the reasons, probably the basic reason, I got very interested in family planning was because I was working in a State health department, where I was dealing with children who nobody wanted, children who were committed to the State, thousands of them. And so I really do not ever agree with the statement that people make that there are thousands of parents out there who will take on children who are thrown away and unwanted by other people.

I also worked for 10 years at a State training school and experienced the same thing—children that nobody wanted, children who had been abused. So I really got into the family planning field to prevent unwanted children coming into this world. And I thoroughly agree—I have a staff of about 200 people, Mr. Chairman, and I know they all agree that every child should be loved and wanted and welcomed into this world, and that is why we work so hard on getting contraceptive services to men and women of any age, race, place of residence, or ability to pay. And I think the point that was made, that what is so good about title X, is that it allows us to give those services to people who otherwise cannot pay for them.

I would also like to say I have heard some talk today about people being proabortion. I would just like to say we have a staff of 200 people. None of them are proabortion. And we have abortion services at three of our sites. But all our staff are prochoice. And I think there is a big difference. In other words, in this free country, where the law is that it is a private matter, and it is an individual choice, it is just as important for a client who comes in to us to be able to choose abortion as to choose natural family planning or any of the other methods.

Senator **Denton**. Some people do regret the Supreme Court decision, which was relatively recent considering the length of our history, making abortions legal. But then, there remains the question, once the girl is pregnant, whether she should abort the baby or permit the child to live—there is life in that womb, and the right to life, according to our Founding Fathers, was endowed by our Creator, and it is mentioned as the first right that any of us have. So you know, we have all of that argument, which I cannot gainsay. I just happen to be of the view that it would be better for the child to be born. And the Russ family and many others who have come through here, testifying, have given a different point of view from yours. They have seen as a fact of life that the girls are not better off having abortions than saving their babies. Every individual I have knowledge of who had an abortion, in my own personal life, regretted it, and said that if she had the experience to go through again, she would bring the child to term and have it adopted, or try to raise it herself. But that remarkable Russ family, of your own State, Ellington, CT, have opened their hearts and their home to nine handicapped, adopted, and foster children. So I cannot agree with your characterization of children not being wanted. I do believe that there is a tremendous waiting list of parents willing to adopt, and we just honestly disagree on our perspective on that.

So thank you very much, Dr. Babbott, for your testimony.

Thank you all for your interest.

[Additional material supplied for the record follows:]

naacog

STATEMENT OF

E. JO ANNE JONES, RN, MSN

PRESIDENT

NURSES ASSOCIATION OF THE AMERICAN COLLEGE

OF OBSTETRICIANS AND GYNECOLOGISTS

TO THE

SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

APRIL 5, 1984

Introduction

The Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG) is a professional nursing specialty organization of 18,000 obstetric, gynecologic, and neonatal nurses.

NAACOG supports the reauthorization of the Title X family planning program as a categorical program. NAACOG further supports the continued funding of nurse practitioner training under Title X.

Many of our nurse members staff the family planning clinics either as public health nurses or as nurse practitioners. The family planning services provided by these clinics continue to be in great demand. Successful family planning substantially improves the health and well-being of the women and their families.

Teenagers and Confidentiality

Although the family planning clinics have been very successful, there are still many sexually active teenagers who do not use any means of contraception. We have had limited success in reaching the many teenagers who need the services.

It has been difficult to get the teenagers to come to the family planning clinics even though there have been few barriers to receiving services. To add the barrier of "mandated parental consent" will not only discourage the unserved teenagers who may have sought services, but it will also decrease the number of teens who are presently choosing to receive family planning services through the clinics.

The assurance of confidentiality was an important factor in serving this population. In a 1980 survey done by the Johns Hopkins Medical School revealed that the assurance of confidentiality was the reason cited by 44 percent of young female patients for their first visit to a family planning clinic; some 33 percent indicated that they had delayed visiting the clinic for an average of one year after becoming sexually active simply because they feared that the clinic would tell their parents.

We are in philosophical agreement that the parents should know when their teenagers receive treatment, care or counseling. However, in view of the reality of the situation, for example the over one million unplanned pregnancies, NAACOG must oppose the mandated requirement of parental consent for teenage services.

Behavioral Research Needed

NAACOG supports continued research on how to get the teenagers to the clinics and how to increase compliance to the family planning regimes. What are the motivators that get teens to use the family planning services and that will keep them coming back for the supervision of their reproductive health care? What educational approaches would be most effective?

Nurse Practitioners

The clinics with high compliance rates are those clinics staffed by nurse practitioners. The nurse practitioners in family planning clinics have been effective in reaching the teenagers and in increasing their compliance rates. A joint statement was developed by NAACOG and ACOG regarding the role description of the obstetric/gynecologic nurse practitioner and published first in 1979. This statement is available through NAACOG.

Eligibility

NAACOG opposes the use of family income to determine the eligibility of those can use the family planning services. This raises an additional barrier in front of those teenagers seeking services from a family planning clinic.

Consequences of Teenage Pregnancy

The number of teenagers in the total population has increased, consequently a greater number of unplanned pregnancies in this population has occurred. According to research reported by the Alan Guttmacher Institute the birth rate among the teenage population is declining.

Approximately fifty percent of teenagers choose abortion. Approximately fifty percent of teenagers choose to carry their infants to term, with the majority of those choosing to keep their babies. The social and economic issues relating to teenage parenting play a greater role in the outcome than the health care issues. While the health care issues are important with adolescent pregnancy, the social and economic affects are of greater importance to both the teenager and her infant. The problems associated with teenagers who drop out of school are well known. Overall, the teenagers have to rely on Federal support, have less schooling, therefore fewer marketable skills in the workplace, and are inadequately prepared either intellectually or emotionally for parenthood.

Summary

The Title X family planning program has been successful and NAACOG believes it should be reauthorized as a separate categorical program. Services should be continued and reemphasized due to the number of sexually active teenagers and the negative consequences of teenage pregnancy. NAACOG supports the confidentiality between the teenagers and the health care providers. NAACOG supports the need for behavorial research to find the motivators that will get the teenagers to the family planning clinics. NAACOG also supports continued funding for nurse practitioner training since many of the Title X clinics are successfully staffed by nurse practitioners who have developed sound teenage programs.

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Community Nursing Services
of Muscatine
615 East 2nd Street
Muscatine Iowa 52761

Family Planning & Maternal
Health Services
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Maternal Health Center
1208 East High Street
Davenport Iowa 52803

Planned Parenthood of
mid-Iowa
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Planned Parenthood of
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University of Iowa
Family Planning Program
Dept of OB & GYN
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TESTIMONY

OF

JILL JUNE

FOR

FAMILY PLANNING COUNCIL OF IOWA

FOR THE

SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON THE TITLE X (PHS ACT) FAMILY PLANNING
PROGRAM

APRIL 17, 1984

Mr. Chairman and Members of the Subcommittee:

At the request of the Honorable Charles Grassley, Senator of Iowa and member of the Committee on Labor and Human Resources I am submitting written testimony to address the deliberations of Congress regarding the categorical reauthorization of the National Family Planning Program, Title X of the Public Health Service Act. As the Executive Director of the Family Planning Council of Iowa, a non-profit Title X grantee, I would first like to express my appreciation on behalf of the Board of Directors for the privilege of submitting their views as voluntary community leaders representing the interests of Iowans in need of family planning services.

Grantee Description

Family Planning Council of Iowa is a private, charitable non-profit organization incorporated in June of 1980. The purpose of this organization is the planning, developing, financing and administration of voluntary reproductive health services. The primary place of business is located at 3500 Second Avenue, Suite 6, Des Moines, Iowa 50313.

Family Planning Council of Iowa (FPCI) believes that preventive health care services will contribute to the improved individual's health and personal satisfaction and will eventually affect the community in terms of promoting the public health and avoiding costs associated in addressing the problems in other publicly financed health, social and welfare programs. Key in all health promotion efforts, family planning services should be offered to the patient and to the community on a strictly voluntary basis and with the utmost regard for the dignity and the privacy of the patient. Rising costs and diminishing resources continue to threaten the continuation of direct services to clients. FPCI remains committed to maximizing public funds through cost effective and efficient administration. Toward this objective, the agency solicits volunteer executive and professional services. In addition, bulk purchasing of laboratory services and supplies continues as an effort to reduce project expenses.

Grantee History and Performance

As a Title X grantee since October 1980, FPCI has maintained compliance with all applicable rules and regulations, including BCRR indicators and appropriate medical standards. According to the 1983 BCRR data, this grantee provided family planning services to 31,639 patients. Based on Table 2B of the BCRR reporting requirements, 20,188 were women reported at or below the 150% of poverty level. The volume of services to this group of low income users presents a 15% increase over the previous reporting period. The penetration rate determined by the target population established by Region VII funding formula was 27.69%.

During fiscal year 1983, $663,302 was approved by the Department of Health and Human Services for the funding of 15 local family planning program sites as delegates of the Family Planning Council of Iowa. There were an estimated 55,100 teens and women 13-44 at risk of pregnancy with incomes below 150% of the federal poverty index in need of subsidized family planning services and residing in the existing 41 county FPCI project area (AGI-WIN 1981). As stated previously, in 1983 programs funded by FPCI provided services to 31,639 individuals. 20,188 of this total were below 150% of the federal poverty index, or 64% of the total served. This represents a 15% increase over the previous reporting period and is of major significance as funding reductions occurred during the budget period.

Family Planning Needs in Iowa

Comprehensive family planning services represents an approach to address the health, social and economic problems associated with the incidence of unwanted and mis-timed pregnancies in the State of Iowa.

Fertility studies have shown that in the United States almost all people, regardless of ethnic, religious or socio-economic background desire to have smaller families and use, or expect to use, contraception. Additionally, effective fertility management has been shown to contribute substantially to the health of mothers and children, as well as to family health and stability.

It has been demonstrated, however, that family planning services are not available to all who need and want them. In addition to many low or marginally low income individuals who have been denied access because of economic barriers, there are many non-poor medical high-risk individuals who experience difficulty in securing and utilizing effective family planning services. In some areas the number of private physicians who provide family planning is limited. In others, health facilities may be geographically inaccessible to those in need of such services. Included among those with other access problems are a large number of sexually active adolescents who may have difficulty obtaining information about birth control and effective contraceptive skills. The long range goal of the Family Planning Council of Iowa is to have available family planning services to all who want and need them.

Services To Low Income

There is no standard national definition of "medical indigency," the point at which individuals cannot afford to purchase private medical care. The issue is further complicated since the income level at which a person would choose to spend limited funds for an elective service such as family planning is believed to be higher than that for emergency medical treatment.

Poverty levels are defined by family size as well as location and income. To wait until families increase to the point of becoming classified as poor or near poor before subsidized family planning care is provided would defeat the program's long range goal of helping individuals and families to avoid the dependency which may be caused by the birth of an unsought child. The universive need for family planning, therefore, includes a group of individuals larger than that which falls below the 100% of poverty guideline. Prior to 1980, "low income" was defined as 150% of the Community Services Administration (CSA) income poverty guidelines. All family planning agencies were advised of the amended rules and regulations (42 CFR part 59), effective June 8, 1980 which reduced "low income" from 150% to 100% of the CSA income poverty guidelines, permitting family planning programs to charge for services on a sliding fee scale for persons falling in the range of 100-250% of these poverty guidelines.

The State of Iowa is divided into 99 counties. 95% of the land is cultivated to support the primary activity agriculture. During the period between 1970 and 1980 population decreased in 42 of Iowa's counties and increased in the other 57. The greatest decreases were experienced in Pocahontas (-11.1%) and in Audubon (-10.8%) counties, while Warren (27.1%) and Dickinson (24.4%) counties increased more than 20% and ten other counties had population gains from 10% to 15%.

Iowa's population grew by 3.1% from 1970 to 1980 but the number of housing units in the state increased by 17.3% during the same period. Thus, housing units grew more than five times as much as population. The difference between these rates of change reflect the decreases in household size.

The estimated child population under age 19 from the 1980 census was 94,885, or 32,4% of the total population -- a decrease from 1970 of approximately 13%. The population group ages 15-19 for 1980 was 207,542, representing 9% of the total population, or an increase of 1.5% compared to 1970. A comparison of 1970 and 1980 data census shows a large increase in women ages 15 through 44. There were an estimated 694.972 women ages 15-44, or 23.9% of the total population, an increase of 25% over 1970. From the above population data it can be seen that Iowa has a slightly growing population with fewer younger children, slightly more adolescents, and a rapidly growing maternity age population, ages 15-44. This is comparable to the national statistics which show a steady increase in the percentage of older population and a drop in the childhood population.

The live birth rate in Iowa has increased steadily from an all-time low in 1973 of 13.6% per thousand to a rate of 16.1 births per thousand in 1979. This absolute number of live births increased from 1975 through 1979 by 13%. The data also shows an 11.8% increase in live births for the white population and a 63.4% increase in the non-white group. The total 1979 non-white births account for only 3.5% of the total births. The increase of Iowa non-white births is due primarily to the influx of Southeast Asian refugees.

Iowa's per capita income of $9,310 in 1980 was slightly less than the national average of $9,511, indicating that the state as a whole is not particularly affluent, nor is there a great concentration of low income individuals residing in Iowa. Counties in the southern, northeastern and west central parts of Iowa recorded per capita incomes lower than state averages in 1980. The same areas have the highest percentage of low income individuals. The high income counties are generally in the metropolitan and those with rich farmland, especially in the northwest and north central portions of the state.

Categorical Reauthorization

The Family Planning Council of Iowa and its delegate agencies typify the system of family planning providers throughout the nation. As a non-profit organization the council enjoys the participation of ministers, teachers, business leaders, parents and elected officials who serve in policy making and advisory capacities. It is through this mechanism of local participation that community values reflective of family ideals are strengthened and assured as part of Title X service delivery. The categorical nature of Title X fosters a partnership between government and community necessary to guarantee a fair and equitable application of national standards and yet permit local influence and design.

It is imperative that all persons seeking family planning services have available comprehensive high quality medical care and supervision regardless of their place of residence. This need, that is evidenced throughout the nation, supercedes all territorial boundries. Congress has thrice affirmed a categorical family planning program and it is our hope that once again you reject the misguided proposal to incorporate family planning into the primary care block grant.

The FPCI has demonstrated the productivity and effectiveness of Title X. The total number of female users served through FPCI during the 12-month period ending December 31, 1983 was 31,639. This figure represents 56% of all Title X family planning users reported as served in the state of Iowa and denotes a 12% increase of FPCI users over the previous 12-month reporting period. The actual increase of FPCI users was 3,344.

During calendar year 1983, 20,188 low income users were served through FPCI. This represents a 15% increase in low income users served from the previous 12-month reporting period for an actual increase of 2,639.

The Title X cost per user for calendar year 1983 was $20.99. representing a $6.31 decrease per user from the previous reporting period.

USER REPORT CALENDAR YEAR 1983

	Calendar Year '82 Total Users	Calendar Year '82 <150 % Users	Calendar Year '83 Total Users	Calendar Year '83 <150 % Users	Increase <150 % Users	Increase Total Users	Increase <150 % Users	Increase Total Users
FPCI								
Total	28295	17549	31639	20188	2639	3344	0.15	0.12
% of State	0.54	0.46	0.56	0.50	1.41	0.95		
ISDH								
Total	24426	20836	24596	20064	-772	170	-0.04	0.01
% of State	0.46	0.54	0.44	0.50	-0.41	0.05		
State								
Total	52721	38385	56235	40252	1867	3514	0.05	0.07

HHS/PHS
Bureau of Community Health Common Reporting Requirements, December 1983

Productivity indicators for CY83 were as follows:

	1983 FPCI	1982 FPCI	STANDARD
PRODUCTIVITY-PHYSICIANS	7485	5932	4200-6000
PRODUCTIVITY-MIDLEVEL & PHYSICIANS	6487	6413	4200-6000
ADMINISTRATION %	13.07%	13.43%	< 16%
COST PER MEDICAL ENCOUNTER	16.44	13.75	$18-$26
ADOLESCENT COUNSELING	99%	99%	90%
PAP SMEAR FOLLOW-UP	100%	100%	100%
HYPERTENSION FOLLOW-UP	99%	100%	80%
TREND - TX COST/USER	20.99	27.30	--
TREND - ENCOUNTERS/USER			
1983	1.74		
1982	2.03		
1981	1.99		
% of LOW INCOME WIN SERVED	36.63%	27.69%	

FAMILY PLANNING COUNCIL OF IOWA

B. PERFORMANCE PROFILE

1. Trend Data - As submitted to PHS Region VII

Using BCRR data from the three most recent reporting periods, complete the following table. Grantees with multiple sites should provide this information on their total program, i.e., a consolidation of all operations. For family planning projects, only complete the applicable lines.

INFORMATION	Most Recent Reporting Period CY83 12 mos. (specify dates)	Prior Reporting Period CY82 12 mos. (specify dates)	Prior Reporting Period CY81 12 mos (specify dates)
Users			
Medical			
Dental			
Migrant			
Seasonal			
Family Planning	31,639	28,295	27,694
Encounters			
Medical	58,613	57,294	55,127
Dental			
Other Health			
Productivity			
Physician (annualized)	7,485	5,851	6,346
Team (annualized)	6,487	5,874	6,243
Dentist (annualized)			
Dental Hygienist (annualized)			
Financial			
Administrative Cost %	13.07%	13.49%	12.78%
Average Cost/Medical Encounter	$16.44	$14.70	$16.61
Average Cost/Dental Encounter			
Clinical (% Compliance)*			
Immunization			
24-27 months			
6 year olds			
17 year olds			
All patients under 18			
Adolescent FP Counseling	99%	99%	99.76%
Pap Smear Follow-up	100%	100%	100%
Hypertension Screening/Follow up	99%	100%	99.76%
Anemia Screening			
24-27 months			
Female Family Planning			
Continuing Care for Children			
Medicaid Certified			
All Others			

Table Source: Primary Care Effectiveness Review Manual, p.38

Restrictions and Accountability

We are pleased to note that both the GAO report issued 9-24-82 and the DHHS Inspector General found no evidence that Title X recipients were in violation of restrictions placed upon the use of Title X funds.

We are likewise happy to report that routine audits are completed for FPCI delegates as well as a system wide Title X compliance review by Arthur Andersen and Company. The most recent examination completed was for the year ended 6-30-83.

The examination was based on the procedures set forth in "Guide for Audits of Financial and Business Management Systems at Federal Assistance Recipients Funded by the Public Health Service," draft dated January 22, 1980, issued by the Department of Health and Human Services (DHHS). The examination covered the period July 1, 1982, through June 30, 1983, and was performed from August 30, 1983, to September 21, 1983, at FPCI's corporate offices and at the offices of subgrantee agencies.

The objectives of the examination were as follows:

1. To express an opinion on the Statement of Assets, Liabilities and Fund Balance and the Statements of Support, Revenues and Expenses;
2. To assess FPCI's internal accounting and administrative controls based on the procedures established in the DHHS Audit Guide;
3. To perform, on a test basis, cost validations of line-item transaction costs and of total project costs;
4. To assess, on a test basis, FPCI's compliance with the prescribed DHHS cost principles (OMB Circular A-122) for selected functional types of costs; and
5. To ascertain whether costs claimed for federal funding under the PHS grant, as shown on the FPCI financial statements, are fairly presented in conformity with the terms of the grant agreement and the DHHS cost principles.

This report determined that family planning activities and expenditures totaling in excess of 1.5 million dollars contained zero dollars in question costs.

Services To Teens

During calendar year 1983 the FPCI provided services to 10,458 women under the age of 20. It is important to recognize that in the majority of instances these young women have contacted the family planning provider for the purpose of obtaining test results regarding a suspected pregnancy.

It is sometimes contended that the availability of family planning services actually increases the incident of teenage pregnancy, because it encourages early sexual activity (Roylance, 1981). As Furstenberg (1981) notes, "In the 50's and 60's more than half of all teenage women entering marriage were pregnant, and many others who became pregnant escaped notice by obtaining illegal abortions. The first reliable national survey on adolescent sexual behavior, in 1971, showed that almost half of all unmarried females were nonvirgins by 19", and this occurred at a time when contraceptive services were not at all widely available. Moore and Caldwell (1976) found no effect of family planning availability on levels of sexual activity during the late 1960's and 1970's but they did find that the probability of conception was higher among black teens living in states with a greater need for family planning services. As noted, only 1 in 10 unmarried teenagers initiates sexual activity protected by a medical method of contraception, further evidence that family planning clinics do not promote sexual activity. Further research on this question is warranted given the sensitivity of the issue; but, to date, there is no evidence that supports the contention that the availability of family planning services to teenagers encourages sexual activity. On the other hand, ample evidence indicates that the use of contraception and the availability of organized family planning services does reduce the incidence of pregnancy among sexually active teenagers.

A major controversy surrounds the issue of parental involvement. Although nowhere near enough research has been conducted on this issue, several preliminary studies have been done. A survey of teenage patients aged 17 and under who obtained a prescription contraceptive at 1 of 53 family planning clinics indicates that a majority of the young women's parents knew of their clinic attendance (66 percent of the parents of teens 15 and younger, 52 percent of those age 16, and 49 percent of those 17 (Torres et al., 1980).

As we are all well aware the courts have struck down attempts by the current administration to require parental notification when minors seek contraceptives at a Title X family planning clinic. We concur that such a requirement is unwise because of the adverse effects on patient confidentiality and because of the likelihood that many teens would view such a requirement as a barrier to contraceptive access.

Increasing contraceptive use among sexually active teens who wish to avoid pregnancy is an important goal. Unfortunately, some teens genuinely face the possibility of abuse or rejection if parents discover their contraceptive use, and other teens would face a greatly increased risk of pregnancy because they would forego contraception or switch to less effective methods. Only 4 percent of the teens in one survey (Torres, 1978) and 2 percent in another (Torres et al., 1980) indicated that they would stop having sex if their parents had to be notified.

Given the numerous other barriers that exist to pregnancy prevention among teens, the mandatory addition of new barriers seems improvident. On the other hand, many advantages could result from the voluntary involvement of parents in the sexual and contraceptive decision making of teens. The initiation of such involvement need not come only from teenagers. Parents should be encouraged and instructed so that they can initiate and carry out such discussions. One clear value of sex education curricula that include parents is the increased probability that discussion will lead naturally to parental involvement. Parent seminars have been developed by the March of Dimes and the National PTA:

> Although most parents have strong beliefs about human sexuality, quite often they don't know how best to discuss the subject with their children. The seminars are designed to help parents to think through their own convictions, to express those convictions, and to explore the strategies that will encourage family discussions (The National PTA, undated).

Such an approach seems far more realistic to us than mandated parental consent or notification. Government involvement at various levels as well as private organizations in developing curricula and model programs for teens and parents seems to be a fruitful way for the government to encourage those most closely involved with the teenager to provide the help, advice and support that teens need.

Toward this end FPCI has promoted parental educational activities through its system of delegates.

Educational reports submitted by FPCI delegate agencies indicate approximately 35,000 family members were served by educational events during calendar year 1983.

Programs offered were targeted toward:

- Elementary and special education students
- Grades 7-12
- College students
- Adult potential patients
- Parents as sexuality educators of children
- Community support groups and governing boards
- Nursing and medical students
- Medical and human service professionals

Program content included:

- Strengthening families and developing capable young people
- Parenting skills (over 300 parents in attendance)
- Parents as sex educators
- Engaging child cooperation
- Families in crisis and unemployment
- Developing positive self esteem in children
- Teaching children assertive behavior
- Family law and legislation
- Values/decision making and birth control.

Special emphasis was directed in augmenting family involvement during National Family Sexuality Education Week (October 5-11). During this time, clinic activities promoted:

- Family fun runs - including T-shirts for all family members
- Poster and essay contests - the theme of the contests was to describe some aspect of parent/teen communication
- Public service announcements on radio and TV modeling parent/child interaction
- Televised mini programs (10 minutes daily) on how parents can develop skills as sex educators of their children
- Statewide conferences for families

Two projects conducted in Des Moines and Omaha/Council Bluffs area are specifically designed to address the special needs of adolescent parents. These programs are supported by local community resources with the assistance of FPCI delegate agencies. Participants who are pregnant or post-partum adolescents form valuable support systems as they gain parenting skills. One of the primary objectives of these parenting projects is to reduce the incidence of repeated pregnancies among adolescents.

The planning process for family involvement activities engages Board and Advisory Council members, both at the grantee and delegate levels. Much support was also contributed by other youth and family service institutions.

All FPCI members and other family planning providers were invited to participate in all Title X sponsored events.

At the November 18, 1983 Board meeting, FPCI delegate agencies reported to the Board of Directors an outline of family involvement planned or already provided during the project period. Also at this same meeting, the FPCI Board of Directors adopted the following family/community involvement statement and activities outline and reaffirmed its policy statement of April 30, 1982:

"Be it resolved that the FPCI recognizes the importance of a supportive nurturing family and encourages client family participation whenever feasible."

Family Involvement Guidelines

I. Counseling

  A. Individual counseling with parent/teen clients is available.

  B. Adolescents are encouraged to invite their parents and involve them in counseling.

  C. During individual counseling sessions with teens, it is emphasized that the parents should be consulted on the best means of contraception.

  D. Individually advise teens how to initiate discussions on sexuality with their parents.

II. Education

  A. Encourage parents, both mothers and fathers, to become sex educators of their children.

  B. Encourage schools and other social agencies to become more involved with sex education in conjunction with parents.

  C. Conduct group education sessions at school for teacher and parent groups.

  D. Conduct programs at various community clubs and organizations explaining family planning and role of the family.

  E. Have available at clinic sites, audio-visual and printed educational material on family planning where adolescents, parents, and significant others can be involved as a unit.

III. Provider Support (Referrals may be considered by staff, both within and outside of the family planning clinic on an as needed basis.)

  A. Social Services

B. Community Health Aides

C. Public Health Nursing

D. School Support Programs

IV. Public Relations/Community Support

A. Discuss the availability of family planning in the context of regularly scheduled meetings, health fairs, etc., involving providers from various health and social service agencies.

B. Informational telephone calls discussing family/community involvement in family planning.

C. Establish contact with various schools, churches, public and private organizations, where the concept of family participation can be promoted.

Additional guidance may be obtained by reviewing two National Clearinghouse for Family Planning Information Bulletins (P.O. Box 2225, Rockville, Maryland 20852).

1) "Health Education Bulletin"
Family Involvement in Family Planning
May 1983, Number 34

2) "Information Services Bulletin"
Family Involvement
May 1983, Number 32

Title X Management

We are sorry to report that there appears to be a great deal of confusion in the overall maintenance of the family planning program since the transfer of the administration of Title X from the Health Resources and Services Administration to the Office of the Assistant Secretary for Health. The Family Planning Council of Iowa has attended numerous meetings called by this office at the regional and national level reportedly for the purpose of gathering grantee input and advice on program direction. To our knowledge and as of this date we have received no written record of the proceedings nor have we any documentation of grantee recommendations. In fact, if it were not for our presence we would be hard pressed to show that these meetings ever occurred.

When activities do occur they appear to reflect the intent of private individuals rather than that of Congress as evidenced by recent judicial decrees concerning the parental notification regulation. Further, it appears that Congress has been defied by this administration's refusal to follow directions specified in P.L. 98-139. By ignoring the instructions of Congress this administration has in effect placed its own political priorities above the adjudicated rights and needs of family planning users throughout the nation. This refusal signals local citizens, like those of us on the boards of non-profit agencies, that little can or will be done to assist us in our effort to assure families have the means necessary to space and time the birth of children.

In fact we are indeed discouraged to not only operate without the support of Washington but to have our efforts diluted by the preparation of proposals and reports that are left unacknowledged and presumably unread. For example, in February 1983, we submitted at the request of this administration a contract proposal outlining activiites to be undertaken for the promotion of parents as the primary sex educators of their children. We prepared for this project in good faith and I repeat upon invitation. We have never been informed regarding the disposition of our proposal, in fact in response to our inquiries we are informed by Mrs. Mecklenburg's staff that they are "piled up on someone's desk".

How can the administration who so whole-heartedly supports parental involvement ignore responses to a national solicitation to carry out its own priorities?

In February 1984, FPCI received the final Regional family planning work plan of activities for fiscal year 1984. We are not pleased to relate that the increases in written summaries, surveys, meetings, reports, seminars, inventories, applications, and concept paper development required by the Federal government will most certainly result in a transfer of resources from patient care to administrative costs. We are further distressed that these expanded Federal requirements may adversely affect the recipients of family planning services in Iowa and diminish the achievements that were so hard won. My concern rests in the desire to prevent a disruption of Iowa family planning care as a result of inefficacious activities.

You can be assured that the Board and staff of the Family Planning Council of Iowa will continue to view the provision of services to families who seek assistance in preventing unplanned pregnancies as our paramount objective.

Written statement for the printed record of the hearing entitled
"Reauthorization of Title X of the Public Health Service Act, Population
Research and Voluntary Family Planning Programs: An Overview"
held on April 5, 1984, Dirksen Senate Office Building,
chaired by The Honorable Jermiah Denton, Subcommittee on Family and Human
Services, Committee on Labor and Human Resources, U.S. Senate.

re: Natural Family Planning

We have practiced the Sympto Thermal Method of natural family planning for more than eight years and have taught the method for four years. While our personal experience has been most rewarding, we are continually amazed at the lack of awareness by the general public of natural methods of family planning. The U.S. Department of Health and Human Services through its agencies and publications dealing with family planning can be of great help in informing people about alternatives available and in providing adequate services for those desiring to use natural family planning.

There are many couples who for ethical, moral, medical or social reasons cannot use artificial means of family planning. They in particular, but all in general, should have the opportunity to become aware of the safety and effectiveness of natural methods. As in other concerns, decisions made in light of sufficient knowledge are the best decisions.

Natural family planning (NFP) consists in fertility awareness and timed intercourse that enables a couple to plan for or avoid pregnancy. Modern methods of NFP are based upon sound scientific knowledge and many years of clinical experience. The DHHS brochure on"Natural Family Planning" (Publication No. (HSA) 80-5621) lists a method effectiveness rate of 98% for the three methods of NFP.

That same brochure points out that NFP has no harmful physical side effects. Thus NFP is an alternative, more effective than barrier methods, for the many, many women who are still of child-bearing age but for whom the Pill or IUD have caused health problems. Furthermore NFP can be practiced as "preventative medicine" by all women so that they can avoid health risks associated with every method of artificial contraception.

NFP requires good instruction and good motivation. The Public Health Service can promote good instruction through community health service programs and through co-operation with private NFP teaching organizations. Such co-operation not only saves tax dollars, but value-based teaching by well-motivated NFP user couples can in turn encourage good motivation on the part of learner couples.

As the DHHS brochure on natural family planning explains, NFP itself promotes co-operation and communication between spouses, and enhances the autonomy and responsibility of married couples. Those qualities make for stronger marriages, and the ramifications of that are certainly among the goals of all of us.

Mary Ann Paulukonis , Jay Paulukonis

Jay and Mary Ann Paulukonis
Country Estates #3, Rt. 1
Madison, SD 57042
(605) 256-2469

Regional Co-ordinators for Natural Family Planning
Catholic Diocese of Sioux Falls, South Dakota

FAMILIES
FOR
LIFE

To: Christi Arbuckle
Office Manager
Subcommittee on Family and Human Services
Committee on Labor and Human Resources

It is respectfully requested that the following be included in the printed record of the testimony of the public hearing of April 5,1984: Reauthorization of Title X of Public Health Service Act

As a result of the exploitation of the original intent of Title X at its inception and consequent approval by Congress, it is requested that the following be added to Title X in the form of restrictions regarding funding(the use of public tax monies)

1) That no funds will be used to perform abortions.
2) That no funds will be used to provide abortion related services.
3) That no funds will be used to influence or lobby any legislative body to enact laws or statutes to provide abortions, abortion services, or laws or statutes denying parental involvement in regards to abortions, or abortion services to minors.
4) That no funds will be distributed to organizations that counsel or provide to minors abortions, abortion related services or contraceptives without parental notification.

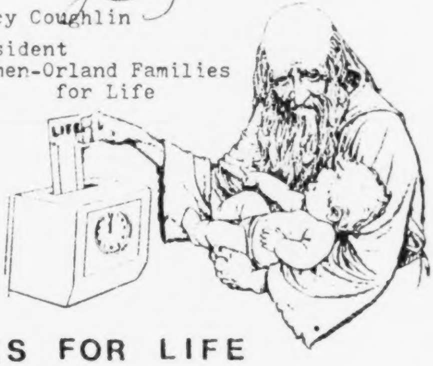
The membership of Bremen-Orland Families for Life believes deeply and strongly in the sanctity of human life, from the beginning of life;conception. We also hold dear the conviction that parents have an inherent right to be informed as to any medication dispensed to their minor children or any surgical procedure performed on their minor children. We strongly object to our tax dollars being used to provide abortions or provide abortion counseling.

Respectfully,

Nancy Coughlin

Nancy Coughlin
President
Bremen-Orland Families
for Life

4/4/84



BREMEN-ORLAND FAMILIES FOR LIFE

P O BOX 671 • TINLEY PARK, IL 60477

Dear Christi Arbuckle,

I ask that Title X Funds not be granted to Planned Parenthood.

Thank You,

Paula S. [illegible]

UNITED METHODISTS FOR LIFE

Dr. Olga Fairfax
(Mrs. Carl)
12105 Livingston Street
Wheaton, Maryland 20902
(301) 942-1627

Planned Parenthood is the largest promoter and performer of abortions.

Title X funds should not be given to this anti-life, multi-national corporation.

Thank-you.

Blessings for life!

Olga Fairfax, Ph.D.

Pray for a Human Life Amendment—Call Your Local Right-to-Life and Get Involved!
Subscribe to: National RTL News • 419 7th Street, N.W., Suite 402 • Washington, D.C. 20004

Joseph J. Giedraitis,
4902 East Copper,
Tucson, Arizona,
85712.

Subcommittee on Family & Human Services,
Committee on Labor & Human Resources,
United States Senate,
Room SD-428, Dirksen Senate Office Building,
Washington, D.C. 20510. April 13, 1984.

The Title X Program should be reauthorized only when the administration demonstrates to Congress that it clearly and fully understands the meaning and intent of the abortion proscription of Section 1008; explicitly outlines that understanding and issues formal guidelines to implement and demonstrates that it is willing and able to enforce related regulations with close programmatic oversight and a tight fiscal management of both direct funding and general program income. Fourteen years of defiance and/or neglect are enough.

Thank you for this opportunity to present material relative to the administration of the federal family planning program solicited in your release of March 21, 1984 announcing a public hearing on the reauthorization of Title X of the Public Health Services Act.

I am Joseph J. Giedraitis and reside at 4902 E. Copper St., Tucson, Arizona, phone (602) 795-3163. I represent no organization and present this material to you in my own name. I feel my perspective is somewhat unique, and believe this material should be made available to you and record. I apologize for its length and hope it is suitable in form and content.

For some years I have been following the development, promulgation and administration of Department of Health & Human Services' policy relative to the abortion proscription in Section 1008, Title X Public Health Services Act. I have been directly involved in HHS reviews of grantees and have reviewed thousands of pages of material, including Office of Inspector General audit work papers and General Counsel opinions, obtained under the Freedom of Information Act. As a matter of fact, the outline of HHS policy in chapter 3 of the Government Accounting Office Report HRD 82-106 is based largely on an OIG interpretation made in response to my inquiry to the Office of Public Affairs, HHS.

The "Dingell Amendment", clarified in its attendant remarks, legislative history and subsequent General Counsel opinions proscribes the use of Title X funds not only for abortion-on-demand, but for abortion related activities, such as counseling and referral (except to preserve the mother's life). Additionally, Congress clearly intended program funds to be a supplement to other family planning funds: not a substitute. Unfortunately, a parade of appointed administrators and civil servants who disagreed with Congressional intent have subverted that intent by putting in place a program that fosters abortion programmatically by ignoring abuses, and fiscally, by countenancing inadequate reporting and accounting practices. The poor are shortchanged.

The enclosed documents are presented in a sequence to demonstrate the following:

A. It has been Congressional intent that abortion, its counseling and referral, its promotion in general and encouragement in the particular are not to be funded by Title X;

and

Office of General Counsel opinions have generally recognized and defined that intent, and required that proscribed activities be funded by distinguishable and separate monies;

but

Various agents in the bureaucracy have ignored, misunderstood or misapplied those opinions, and did not write or promulgate guidelines that adequately implemented those opinions;

and

Even though reviews and audits have verified that the abortion proscription has been ignored, the administration will not or cannot issue guidelines to implement corrective measures. Years have passed since the GAO and IG audits, and the Department has yet to respond to the Comptroller General's Final Report, "Restrictions on Abortion and Lobbying Activities in Family Planning Programs Need Clarification."

B. In violation of Federal Regulations national and regional administrators have allowed General Program Income to become Grantees' private funds useable for activities not consonant with the broad objectives of the statute; i.e. activities that promote or encourage abortion as a method, lobbying, politicking, and investing. These unauthorized uses deprive the poor of authorized services by diminishing the total amount of funds available from all sources for a family planning program consistent with Congressional aims.

Index and Summary of Enclosed Documents:

1. Brief (Civil No. A3-79-87) presented by State of North Dakota in re: Valley Family Planning, et al., Plaintiffs - vs - The State of North Dakota, et al., Defendants, pages 3-10 and exhibits A. This section of the brief is a discussion of Con-

gressional intent and HHS/OGC interpretation which argues that Title X funds were not intended for post-conceptive counseling or referral. It includes, as exhibits, the HHS memos and OGC opinions available to me at that time (1979).

2. 661 Federal Reporter, 2nd Series, pages 100-102 indicates the Appeals Court interpreted that Title X apparently mandated referrals for abortion if a woman's life would be endangered if she carried the pregnancy to term. Mr. Joel Mangel, an attorney with HHS testified and apparently submitted an opinion dated July 25, 1979 from Carol Conrad, Senior Attorney, Public Health Division to Bureau of Community Health Services.

3. The above cited opinion indicates that a grantee is not required to make referrals to a provider who might provide an abortion, unless there is a medical indication; e.g. the mother's life is endangered. Clearly the types of referrals indicated in the GAO and IG reports do not meet these criteria.

4. Letter from Assistant Secretary for Management & Budget dated April 19, 1983 listing twelve denied documents. They are the series of legal opinions that "draw a fine line between allowable and non-allowable activities" mentioned in the GAO audit report. I do not know who wrote, "Why not finalize and direct grantees to comply", in the memo dated May 7, 1979.

5. Letter dated August 15, 1975 from Representative Morris K. Udall to Mr. Joseph J. Giedraitis. It states, "Under Family Planning Services Act abortions and abortion referrals are not allowed; the agency is closely watched."

6. Summary by the Inspector General auditor of Planned Parenthood of Southern Arizona of OGC opinions and other documents which were furnished to him to serve as audit guidelines. This summary points out that abortion related activities cannot be part of the federal Title X program. They must be separate and distinct. The referenced memo dated January 31, 1979 on page 5 of 18 has not been released to me under the Freedom of Information Act. It is very pertinent and probably refers to the PPSA audit to take place in May 1979. It should be made part of your record. I recommend you obtain it.

7. Report of PHS Review of Planned Parenthood of Southern Arizona, my critique, and Dr. Richmond's answer. It appears that until May, 1979 family planning officials at the Public Health Service and Health Services Administration did not conduct a full onsite review of any grantee to determine compliance with the abortion proscription in Section 1008. Planned Parenthood of Southern Arizona was a first and its review became a precedent. Its report and my comments were included with documents forwarded to District Inspector General Auditors as an informational guide. You'll note that the PHS review team found programmatic problems which it rationalized as insignificant, the result of faulty bookkeeping and instructions, and non-implementation of Section

1006, which does not allow more than a 10% grantee match. This review is that mentioned on page 21 of the GAO report of September 1982.

8. Letter from the Chief Librarian, Library of Congress dated January 4, 1983. It states that the Conference Report is the only record it has on the part of the managers of the Family Planning and research Act of 1970.

9. Letter from National Archives. It states that it has no record on minutes of proceedings of the Conference on S2108, 91st Congress.

10. Memo dated December 9, 1971 from DASPA on abortion policy, including a memo from Administration for Health Delivery Services to Region X's Health Director dated December 2, 1971. This very significant memo advocates a policy recognizing abortion counseling as a medical necessity. It documents the early discussion of how the Department was going to handle the abortion proscription.

11. Memo dated February 22, 1973 from Chief, OFO, NCFPS. It indicates that the January 1973 Supreme Court Decision had no impact on Title X and that Planned Parenthood would be well advised, "to establish any new abortion activities as separately as possible. The Staff should be different from the contraceptive services Staff and if possible, the physical location should be outside the regular location of the Planned Parenthood affiliate or any other NCFPS grantee." This very significant early memo suggests a policy very similar to the policy proposed by Dr. Graham in 1982, which was withdrawn.

12. A memo - "Discussion Information re DASPA Memo 1-31-72 on Abortion and Title V - Title X." This very significant document suggests a need to define certain terms - "preventive family planning", "Only to support a medically necessary, informational and educational activities", "pregnancy counseling", "abortion counseling", "referral for abortion", and other terms. It also presented, "Some Options". "We can allow each region to develop its own response. We can suggest that inquiries be referred to NCFPS and/or HSMHA General Counsel. We can suggest that Regions avoid encouraging written requests or we can solicit them. We can avoid written responses. We can propose a Director's memo, and clear it at HSMHA or DASPA levels. We can explore some of these ideas or points verbally with HSMHA/DASPA." It appears that they decided to run a closed shop. I recommend that the January 31, 1972 memo and associated documents be obtained and be made part of your record.

13. Memo dated March 16, 1981 from Acting Assistant Inspector General for auditing to Audit Director, San Francisco Regional Office. It suggests problems at PPSA, PHS, BCHS and Regional Offices of PHS relative to monitorship of the abortion proscription in Title X.

14. Memo dated June 1, 1981 from Associate Director - OIG Audit Agency to Regional Director, instituting audits to determine whether Title X funds are used for unallowable costs. It indicates, "The WAAO survey has identified deficiencies in guidelines issued by headquarters to the Regions. These guidelines did not clearly explain which steps should be taken by grantees to ensure compliance with Title X proscriptions on abortion related activities. Regional officials may not be taking effective action to detect the failure of PPO's accounting systems to distinguish Title X funds and expenditures from private sources of funds and expenditures. It also appears that compliance with requirements on abortion related activities, political lobbying and contributions may be a low priority item at PHS."

15. Papers included in material furnished as "Copies of Working Papers that Pertain to Review at PHS, ACN 21467". The page of "1978 Annual Agency Statistics" of Planned Parenthood of Marin indicates that there were 669 referrals for abortion from a total number of 871 positive pregnancy tests in 1978. The memo about the meeting of November 3, 1980 with HSA officials to his work papers by John Barrett of the Washington area audit office indicates that HSA did not follow-up on Dr. Kushner's recommendations but that grant application procedures were being clarified.

16. My letter to Dr. Brandt dated March 9, 1983. It points out the inconsistencies in the memo of Abigail Cummings, Attorney, OGC/Inspector General Division to OIG Audit Agency relative to the GAO audit of Planned Parenthood of New York City - Report dated May 28, 1981. A review of OIG audit work papers indicates that grant funds are accounted for on a percentage rather than an actual itemization of costs. If Ms. Cummings opinions are correct, Section 1008 has absolutely no meaning and should be deleted from the law. The opinion and report are also included.

17. My letter to Secretary Schweiker dated November 3, 1982 outlines my objection to the OIG interpretation of abortion referral in certain audits. My letter to the Inspector General of February 10, 1983 reviews the audit work papers of PPSA. My letter of August 3, 1983, reviews the audit work papers of Planned Parenthood of Seattle-King County. Both list unreported problems evident in those work papers.

18. Letter dated January 5, 1982 to Deputy Director Office of OIG from Vice President for Legal Affairs of Planned Parenthood Federation of America, Inc. This letter asks that the Federation be advised of terms and policies. My Freedom of Information request of OIG asks for those same definitions - "lobbying" "abortion", "federal program funds" and "monies properly to be considered Title X monies". The letter dated April 13, 1983 from HHS states that "To the best of our knowledge, the other definitions referred to suggested by Ms Paul's letter were never developed. The other correspondence points out that the program continues to run without adequate guidelines.

19. Memo of May 4, 1976 from Director, Office of Administration Management to Regional Health Administrators - Region X. It discusses how program income is to be handled and states that although all program income is to be retained by the grantee it must comply with grant restrictions, and that all income generated by the total program outlined in the approved grant budget is to be considered to be restricted General Program Income. Those grantees, whose work papers I have reviewed seem to be able to use general program income in ways not in-keeping with this memo and 45 CFR Sub part F Part 74.42(d). The tens of millions of dollars so generated are thus not properly used. See enclosed pages of PPSA - CIG Audit. Those work papers also indicate that the 10% limit as grant match in Section 1006 is largely ignored. If that requirement were enforced, less direct federal funding would be required, since the amount of each project would be limited to the amount designated in the Notice of Grant Award and direct funding would be decreased by some portion of General Program Income. An official of HHS' Office of Management and Budget confided that the Office was too shorthanded to expend its limited resources in a close supervision of a controversial program where only tens of millions of dollars are involved, a very small percentage of the Hundreds of Billions it spends.

The GAO Report commented, "Because the distinction between the recipient's Title X and other activities may not be easily recognized, the public can get the impression that Federal funds are being improperly used for abortion activities." I believe the enclosed documentation supports and justifies that public perception. It is the organization techniques employed by the bureaucracy that are unsupportable and unjustified. They render the non-encouragement intent of the abortion proscription meaningless.

Because of limitations of time, space and money I have presented only some documents I believe germaine to your inquiry. I should be happy to answer your questions and furnish additional material. The hand written annotations on some of the submitted documents are not intended to be part of my testimony. Each page is identified by its document number (1-19) and sequence number (1-180).

Respectfully submitted,

Joseph J. Giedraitis.

Senator **Denton**. This hearing stands adjourned.

[Whereupon, at 1:50 p.m., the Subcommittee was adjourned.]

OVERSIGHT OF FAMILY PLANNING UNDER TITLE X OF THE PUBLIC HEALTH SERVICE ACT, 1984

TUESDAY, MAY 1, 1984

U.S. SENATE,
SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room SD-430, Dirksen Senate Office Building, Senator Jeremiah Denton (chairman of the subcommittee) presiding.

Present: Senator Denton.

Senator DENTON. Good morning. This hearing will come to order. I would like to welcome our witnesses to the second hearing on the reauthorization of title X of the Public Health Service Act.

On April 5, we heard testimony from the administration, State officials, representatives of the family planning community, and concerned organizations about the provision of family planning services to low-income families and minor children.

The subcommittee received suggestions about how we can make improvements in the Family Planning Program. When combined with the findings of the five other hearings that this subcommittee has held in the last 3 years, the results of the April 5 hearing, I believe, point toward the formulation of changes in the title X program.

In today's hearing, we will have the opportunity to hear from a State senator who is concerned about his State's ability to develop its own policy with respect to the treatment of minors. Another witness will discuss the provision of infertility and adoption services through family planning programs.

A distinguished pediatrician, Dr. Reed Bell, was scheduled to discuss parental involvement in the provision of birth control services to minors. Unfortunately, an illness in the family has prevented his appearance today. His statement will be included in the record, however, without objection at the conclusion of today's proceedings.

Finally, one private sector group will share its knowledge which it has gained in providing pregnancy testing, counseling and care services in centers across the country.

I look forward to hearing our witnesses testify on these important subjects and assure them that their views and those that we will receive in writing will be taken into account as we consider reauthorization of the title X program.

As a matter of information and courtesy, I must mention that the chairman of the overall committee, the Labor and Human Resources Committee, Senator Orrin Hatch, very much wanted to be with us today. He has a longstanding and deep interest in the work of the Family and Human Services Subcommittee.

Moreover, he was especially regretful that he could not be here to greet Senator Flamm, the State senator to whom I referred who is from Utah. Rather than simply hearing about families, however, Senator Hatch is today witnessing the beginning of one as the father of the groom and took that occasion to excuse himself from the Senate, a wedding, understandably, having priority over a day's work here.

He has provided a written statement addressing aspects of family planning affecting Utah and has indicated that he will be active during reauthorization of the title X program. I would like to read an excerpt of his fine statement now. This is from a lengthy statement, the totality of which will be included in the record, without objection.

I take up in the middle of his statement:

> Parents in Utah want to counsel their children concerning sexuality, or at least become aware of their children's questions and concerns. In 1980, when no parental consent was required, birth for females in Utah between the ages of 15 and 19 were the third highest in the Nation, 69,000.

That number amazes me because when dealing with Utah and the particular example that he is going to mention here, I have heard people say, well, Utah is a very conservative State and they are not significantly affected by this problem.

I imagine he means third highest rate in the Nation. It does not say that, but anyway third highest rate.

> In 1980, when no parental consent was required—that is, for contraceptive services, counseling and that sort of thing—birth for females in Utah between the ages of 15 and 19 were the third highest rate in the nation, 69,000.
>
> Once parental involvement was at least encouraged by family planning agencies, the incidence of teen pregnancies declined slightly and abortion dropped in Utah by seven percent in two years. Expecting youngsters to make critical decisions about their sexuality, morality and future without the benefit of support and wisdom from their parents is cruel and, as history has proven, ineffective.

I go on with the quote:

> I remind the subcommittee that over the past decade we have spent $1.5 billion on family planning. Can it be purely coincidental that as the government continues to spend millions of dollars providing contraceptives to teens without their parents' knowledge or consent, the problems related to adolescent sexual activity grow worse?
>
> What have we gotten for our money? Fewer teenage pregnancies? Fewer cases of venereal disease victims? No. Teenage pregnancies are skyrocketing. Venereal disease and other sexually transmitted diseases are increasing. In light of these facts, it is incredible that there are some who are not willing to step back and reevaluate, even redesign a public health program to reduce and prevent the tragedies associated with these problems.

Going on with the quote of Senator Orrin Hatch:

> I believe that improvements can and should be made. I challenge and urge my colleagues to support revisions in the Title X program to strongly encourage parental involvement in the delivery of family planning services, to strengthen adoption counseling and infertility services, to continue providing venereal disease and cancer screening services to low-income women, and to allow states flexibility in administering state-granted family planning programs.

I urge Senator Denton and other members of the Family and Human Services Subcommittee to seriously consider these recommendations in their legislation reauthorizing Title X of the Public Health Services Act."

Senator DENTON. That is the end of the excerpt from Senator Hatch's statement.

[The full text of Senator Hatch's prepared statement follows:]

STATEMENT OF SENATOR HATCH

Senator HATCH. I am pleased to join Senator Denton in this second day of hearings on title X of the Public Health Service Act: Family planning. Family planning legislation traditionally has been authorized and examined under the jurisdiction of the Family and Human Services Subcommittee which is chaired by my good friend and distinguished colleague, Senator Denton. The family planning issues are of deep personal concern to Senator Denton as they are to me. I commend his legislative leadership in pursuing a proper examination of these federally funded programs.

On October 6, 1980, I received a letter from the Utah Weber Area Council of Governments which reads in part:

> The Weber Area Council of Governments, along with other public bodies in Weber county, had adopted a rather conservative approach to "family planning" over the years based upon a generally accepted community philosophy and belief that such matters should not be mandated by government but rather that responsibility rests with parents and families to provide such important and intimate enlightenment and direction to maturing youth in line with the parents' and families' beliefs and moral standards. However, decisions by Congress and the Supreme Court have resulted in government intrusion into this segment of our family life by providing funds for family planning, abortions, sex education, providing for contraceptives, etc. by groups and organizations outside the home to youth. In many cases, without the knowledge or approval of parents * * * to provide counseling outside the home, abortions upon demand without parental knowledge or consent and supplying contraceptives and other birth prevention devices and information.

I believe this letter reflects the viewpoint not only of Utahns but of most Americans. We will hear more to illustrate this point during the testimony of Utah State Senator Bryce Flamm who brings a special Utah insight into the reauthorization of title X programs. He can provide us with background on the problems of the State of Utah in complying with Federal law and in administering family planning programs. He is indeed a leader in our State in retaining parental rights and responsibilities in the delivery of family planning and other related services.

Parents in Utah want to counsel their children concerning sexuality—or at least become aware of their children's questions and concerns. In 1980, when no parental consent was required, the birth rate for females in Utah between the ages of 15 to 19 was the third largest in the Nation, 69,000. Once parental involvement was at least encouraged by family planning agencies, the incidence of teen pregnancies declined slightly and abortion dropped in Utah by 7 percent in 2 years. Expecting youngsters to make critical decisions about their sexuality, morality, and future has proven ineffective.

Finally, I remind the subcommittee that over the past decade we have spent $1.5 billion on family planning. Can it be purely coincidental that as the Government continues to spend millions of dollars providing contraceptives to teens without their parents' knowledge or consent, the problems related to adolescent sexual activity grow worse? What have we gotten for our money? Fewer teenage pregnancies? Fewer cases of venereal disease victims? No; teenage pregnancies are skyrocketing. Venereal disease and other sexually transmitted diseases are increasing. Even in light of these facts, it is incredible that there are some who are not willing to step back and reevaluate, even redesign a public health program to reduce and prevent the tragedies associated with these problems.

I believe that improvements can and should be made. I challenge and urge my colleagues to support revisions in the title X program to strongly encourage parental involvement in the delivery of family planning services, to strengthen adoption counseling and infertility services, to continue providing venereal disease and cancer-screening services to low-income women, and to allow States flexibility in administering State-granted family planning programs.

I urge Senator Denton and other members of the Family and Human Services Subcommittee to seriously consider these recommendations in their legislation reauthorizing title X of the Public Health Services Act.

Senator **Denton**. We have before us Senator Bryce Flamm, our first witness, a Utah State senator. Mr. Flamm has served as a distinguished State senator for 4 years. For the past 2 years, he has been the chairman of the Appropriations Subcommittee on Social Services and Health.

He served as a city councilman for 8 years in North Ogden, UT. In his private pursuits, Mr. Flamm has served on the foundation boards of several institutions, including the Boy Scouts of America.

He is a successful businessman and is the father of 7 children and the grandfather of 15 grandchildren.

Welcome, Senator Flamm, and you are welcome to begin your statement. If you care to summarize it, the complete statement will be included in the record, without objection.

STATEMENT OF HON. BRYCE FLAMM, A STATE SENATOR FROM THE STATE OF UTAH

Senator **Flamm**. Thank you, Senator Denton.

Family planning was a wonderful theory and 10 or 12 years ago, as the idea was maturing, we had great hopes that we could slow down or decrease the number of pregnancies, abortions, and live births to teenagers. But it appears that someone has poured gasoline on the fire, at least in our State. Until Senate bill 3, that is exactly what appeared to be taking place.

The more we talked about it and the more we trained these young people without parental consent, it seemed the more the problem grew. I put a letter on your desk and on the desks of the other Senators, and I would like to read it and would ask your indulgence if I would add your name to this.

The letter would be addressed something like this:

> Senator and Mrs. Jeremiah Denton, your daughter has come to us to learn of and possibly receive contraceptive and abortion services. Would you please sign and give your consent to this educational and possibly medical arrangement? This could include arranging for birth control pills or the use of an IUD. She could possibly receive an abortion without your knowledge if she should get pregnant. This is, of

course, to guarantee her rights of privacy. The Kanter-Zelnik study indicates that about 40 percent of the teens using contraceptives do get pregnant.

Please sign your name giving permission for these arrangements. P.S.: We did perform abortions on approximately four percent of the white teenage girls ages 15 to 19 in your state last year. At the present rate, we will perform abortions on over 20 percent of our teenage girls during their teens.

The rate of abortion for nonwhite girls in Washington, Florida, Massachusetts, California, and Rhode Island is over 10 percent per year, and over 50 percent of these girls will have abortions before the age of 20.

I think that is kind of shocking. I enclose with it a 1980 chart showing the various States and their rate of abortion, and it shows that California has 4.6 percent of the whites and Rhode Island has 13.3 percent of the nonwhites who received abortions in that 1 year that were between the ages of 15 and 19.

Now, in 1981 the trend took a dramatic change in the State of Utah with the introduction of Senate bill 3. Senate bill 3 in section 2 states, "that no public funds shall be used to provide contraceptive or abortion services to an unmarried minor without prior written consent of the minor's parent or guardian."

There were some strings attached. There was a misdemeanor charge placed if you should do this and we feel that this could have contributed very dramatically at least to the change that took place.

We feel that States should be allowed to use this or similar legislation for several reasons; four of the reasons I have outlined. First, we believe the Constitution guarantees parents this right. They have the right to teach their children religious values without interference from government.

I did include a copy of Supreme Court decisions on page 20 on to about page 25 for each of you to look at, and it clearly states that parents have this right.

The second reason is that we believe that all major churches promote sexual purity, and when the government not only condones but finances immoral acts, they encourage it. The government could be viewed to be in opposition to church teachings for our youth.

We feel, as the Supreme Court does, that parents have the right and responsibility to teach their children moral and religious values. We also think that if a child came home with a statement like the one I just read asking for permission, there are some sleepy parents that might wake up and they might say, my little 14-year-old daughter comes and asks for this kind of permission because her friends are doing it; maybe it is time we talked with her and taught her a little more clearly what the responsibilities are of sexual activity.

No. 3, if government should intervene, we would ask should it be the Federal Government or the State if we need government involvement. In all other matters regarding youth, the State rules, not the Federal Government. The State decides when a youth is emancipated, the degree of their educational requirements, the age they can marry without parental consent, even the age that they can get a driver's license. That is very important to most of them.

So we think that the State should have this opportunity to make the decisions. And our fourth item is we feel it is unconscionable to tax parents and then use the money that we tax from them to go behind their backs without their knowledge or consent to finance immoral acts referred to by every church as unrighteous.

Now, we would request a waiver or something that would allow the State to perform and operate under Senate bill 3. I did enclose some figures that show the before and after Senate bill 3 statistics, and it shows that before Senate bill 3, we were having an annual increase from 1975 to 1980, on the very bottom part.

Pregnancies were increasing 5 percent, abortions 10 percent per year, live births 4.4 percent. After Senate bill 3, in 1981 and 1982, we decreased 3 percent per year on pregnancies, 2.5 percent on abortions, and live births, 3.2.

Now, we do not know that this is the best method. Other States may come up with a better solution even than this, but at least since S. 3 we have gone the right direction and not the wrong.

I thank you.

[The prepared statement of Senator Flamm follows:]

UTAH STATE SENATOR BRYCE FLAMM

(R-UTAH)

TESTIMONY BEFORE THE SENATE LABOR AND

HUMAN RESOURCES COMMITTEE

SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES

ON THE REAUTHORIZATION OF

TITLE X PROGRAMS

Chairman Denton and honorable Senate committee members;
I would like to read aloud the letter I gave to each of you.
Does it shock you?

You have received copies of Utah's intent language and Senate Bill 3-1981.

Section 2 of SB3 addresses our concern directly. It states that "no public funds shall be used to provide contraceptive or abortion services to an unmarried minor without the prior written consent of the minor's parent or guardian.

We feel that any state should be allowed to use this or similar legislation for several reasons, namely:

1. The constitution guarantees parents this right. They have the right to teach their children religious values without interference from government. I have a copy for each of you of United States Supreme court decisions which clearly state this.

2. We believe that all major churches promote sexual purity. When the government not only condones, but finances immorality, they encourage it. The government could be viewed to be in opposition to church teachings for our youth.

   We feel as does the Supreme court that parents have the right and responsibility to teach their children moral and religious values.

3. IF GOVERNMENT SHOULD INTERVENE, IT SHOULD BE THE STATE AND NOT THE FEDERAL GOVERNMENT. IN ALL OTHER MATTERS CONCERNING YOUTH, THE STATE RULES, NOT THE FEDERAL GOVERNMENT. THE STATE DECIDES WHEN YOUTH ARE EMANCIPATED, THEIR DEGREE OF EDUCATIONAL REQUIREMENTS AND THE AGE THEY CAN MARRY WITHOUT PARENTAL CONSENT.

4. WE FEEL IT IS UNCONSCIONABLE TO TAX PARENTS AND THEN USE THIS MONEY TO GO BEHIND THEIR BACKS, WITHOUT THEIR KNOWLEDGE OR CONSENT, TO FINANCE IMMORAL ACTS REFERRED TO BY EVERY CHURCH AS UNRIGHTOUS.

WE REQUEST A WAIVER FOR UTAH AND ANY OTHER STATE THAT DESIRES TO TRY THEIR OWN PROGRAM. HOW ELSE CAN WE COMPARE WHETHER OUR PROGRAM IS THE BEST OR EVEN GOOD. THE PRESENT PROGRAM FOR TITLE X HAS BEEN FORCED NOW ON EVERY STATE. IT'S WHOLE PREMISE WAS A THEORY THAT HAS FAILED MISERABLY.

I WOULD LIKE NOW TO GIVE YOU UTAH'S FIGURES BEFORE SB3 AND AFTER. WE HAVE SOMETHING TO COMPARE. I COMBINED ALL TEENS FOR THE FIGURES FOR ALL YEARS BECAUSE THEY HAD BEEN ARBITRARILY SEPARATED. THE FIGURES ARE DRAMATIC.

THEY POINT OUT WHY STATES SHOULD BE ALLOWED TO RUN THEIR OWN PROGRAMS. THERE MAY BE EVEN BETTER PROGRAMS THAN OURS WAITING TO HAPPEN.

I ESTIMATE THAT OUR RATES OF TEEN AGE PREGNANCY, ABORTION, AND LIVE BIRTHS WOULD NOT HAVE INCREASED FROM 22% TO 50% FROM 1975 TO 1980 HAD WE HAD THE PROGRAMS DURING THESE YEARS, BUT MAY HAVE EVEN DECREASED.

WE BELIEVE THAT PARENTS WOULD WAKE UP AND TEACH THEIR CHILDREN IN MANY HOMES IF THEY RECEIVED THE LETTER THAT EACH OF YOU RECEIVED TODAY. I ALSO HAVE COPIES OF BAR GRAPHS ON ABORTIONS IN VARIOUS STATES. YOU CAN SEE WHERE STATES HAVE FOUGHT BACK.

THANK YOU.

OUTLINE FOR FAMILY AND HUMAN SERVICES SUBCOMMITTEE

BY STATE SENATOR BRYCE C FLAMM OF UTAH
MAY 1, 1984

I. COPY OF LEGISLATIVE INTENT

II. COPY OF UTAH SENATE BILL NO. 3, 1981

III. CONSTITUTIONAL QUESTIONS:

  A. SEPARATION OF CHURCH AND STATE

  B. MORALITY VS IMMORALITY - CHURCH AND STATE

  C. PARENTAL VS GOVERNMENTAL RESPONSIBILITY

  D. STATE AND LOCAL VS FEDERAL RESPONSIBLITY

  E. RIGHT TO TAX PARENTS TO FURNISH SERVICES OPPOSED BY PARENTS WITHOUT PARENTAL CONSENT OR EVEN THEIR KNOWLEDGE

IV. REQUEST FOR WAIVER

  A. ALLOW UTAH TO RUN THEIR OWN PROGRAM FOR TEN YEARS

    1. COMPARE INCIDENCES OF DISEASE

    2. COMPARE PREGNANCIES OF 13 TO 17 YEARS OLD

    3. COMPARE ABORTIONS OF 13 TO 17 YEARS OLD

    4. COMPARE COSTS TO GOVERNMENT

STATEMENT OF INTENT

IT IS THE INTENT OF THE LEGISLATURE THAT ALL TITLE X FAMILY PLANNING FUNDS COMING INTO THE STATE OF UTAH BE ADMINISTERED THROUGH THE STATE DEPARTMENT OF HEALTH, AND THE STATE DEPARTMENT OF HEALTH SUBCONTRACT WITH UNITS OF STATE GOVERNMENT AND WITH LOCAL GOVERNMENTS OF STATE, ALLOWING LOCAL GOVERNMENTS THE FREEDOM TO DESIGN, ESTABLISH, AND MAINTAIN FAMILY PLANNING PROGRAMS WHICH MEET THE STANDARDS, NEEDS, AND INTERESTS OF THE COMMUNITIES MAKING APPLICATION AND THE MINIMUM FEDERAL REQUIREMENTS OF THE TITLE X PROGRAM.

CHAPTER 123

S. B. No. 3 (Passed March 4, 1981. In effect May 12, 1981.)

CONTRACEPTION OR ABORTION SERVICES OR DEVICES

AN ACT RELATING TO CONTRACEPTION AND ABORTION; PROVIDING THAT NO PUBLIC FUNDS SHALL BE USED TO PROVIDE CONTRACEPTIVE OR ABORTION SERVICES TO AN UNMARRIED MINOR WITHOUT PARENTAL OR CUSTODIAL CONSENT; AND PROVIDING THAT NO PUBLIC AGENCY SHALL APPROVE ANY APPLICATION FOR PUBLIC FUNDS FROM AN ORGANIZATION THAT PROVIDES CONTRACEPTIVE OR ABORTION SERVICES TO AN UNMARRIED MINOR WITHOUT PARENTAL OR CUSTODIAL CONSENT.

Be it enacted by the Legislature of the State of Utah:

Section 1. Contraceptive and abortion services—Definitions.

As used in this act:

(1) "Contraceptive services" means any material, program, plan, or undertaking which provides instruction on the use of birth control devices and substances, encourages individuals to use birth control methods, or provides birth control devices.

(2) "Abortion services" means any material, program, plan, or undertaking which seeks to promote abortion, encourages individuals to obtain an abortion, or provides abortions.

Section 2. Public funds for provision of contraceptive or abortion services restricted.

No public funds shall be used to provide contraceptive or abortion services to an unmarried minor without the prior written consent of the minor's parent or guardian.

Section 3. Public funds for support entities providing contraceptive or abortion services restricted.

No public agency shall approve any application for public funds to support, directly or indirectly, any organization or health care provider that provides contraceptive or abortion services to an unmarried minor without the prior written consent of the minor's parent or guardian. No institution shall be denied state or federal funds under relevant provisions of law on the ground that a person on its staff provides contraceptive or abortion services in that person's private practice outside of such institution.

Section 4. Violation of restrictions on public funds for contraceptive or abortion services as misdemeanor.

Any agent of a state agency acting alone or in concert with others who violates section 2 or 3 is guilty of a class B misdemeanor.

Approved March 26, 1981.

CHAPTER 124

S. B. No. 15 (Passed February 13, 1981. In effect March 10, 1981.)

HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT AMENDMENTS

AN ACT RELATING TO PUBLIC HEALTH; PROVIDING FOR THE CREATION OF A PUBLIC BENEFIT CORPORATION TO ACT, UNDER THE DIRECTION OF ITS GOVERNING BODY, AS THE HEALTH SYSTEMS AGENCY FOR THE STATE; PROVIDING FOR THE COMPOSITION, POWERS, AND RESPONSIBILITIES OF THE CORPORATION'S GOVERNING BODY; PROVIDING FOR REPEAL OF THIS ACT EFFECTIVE JULY 1, 1983; AND PROVIDING FOR AN EFFECTIVE DATE.

THIS ACT AMENDS SECTIONS 26-34-7 AND 26-34-20, UTAH CODE ANNOTATED 1953, AS ENACTED BY CHAPTER 95, LAWS OF UTAH 1979, AND REPEALS SECTIONS

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UTAH STATISTICS

Population	1975	1976	1977	1978	1979	1980	1981	1982	Increase each 3% to Comparable to 1980
18 and 19	26,818	27,693	28,214	29,087	29,939	30,253	27,759	29,229	
15 to 17	37,395	37,756	38,177	37,944	37,532	36,707	35,776	35,725	
TOTAL TEENS	64,213	65,449	66,391	67,031	67,471	66,960	63,535	64,954	66,903
						+2,747		-2,006	
						+ 4%		- 3%	
PREGNANCIES									
18 and 19	2,794	2,896	3,217	3,382	3,615	3,575	3,479	3,285	3,384
15 to 17	1,370	1,470	1,590	1,531	1,615	1,658	1,519	1,467	1,511
	4,164	4,366	4,807	4,913	5,230	5,233	5,098	4,752	4,895
						+1,069		- 481	- 338
						+ 25%		- 9%	- 6%
ABORTIONS									
18 and 19	378	384	487	464	536	537	525	485	500
15 to 17	198	241	234	227	302	317	274	297	306
	576	625	721	691	838	854	799	782	806
						+ 270		- 72	- 48
						+ 50%		- 8%	- 5%
LIVE BIRTHS	3,588	3,741	4,086	4,222	4,392	4,379	4,299	3,970	4,096
						+ 791		- 409	- 283
						+ 22%		- 9.3%	- 6.2%

Senator and Mrs. __________,

Your daughter has come to us to learn of and possibly receive contraceptive and abortion services. Would you please sign and give your consent to this educational and possibly medical arrangement? This could include arranging for birth control pills or the use of an I.U.D. She could possibly receive an abortion, without your knowldege, if she should get pregnant. This is of course to guarantee her rights of privacy.

The Kanter-Zelnik study indicates that about 40% of the teens using contraceptives do get pregnant.

Please sign your name giving permission for these arrangements.

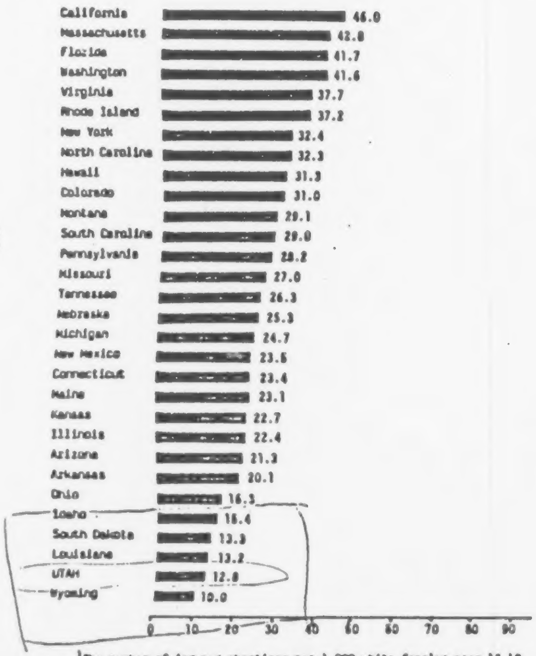
I/We consent ______________________________

____
date

p.s. We did perform abortions on approximately 4% of the white teenage girls, ages 15-19 in our State last year. At the present rate, we will perform abortions on over 20% of our teenage girls during their teens. This rate has nearly doubled the past 10 years. The rate of abortions to non-white girls in Washington, Florida, Massachusetts, California and Rhode Island is over 10% per year and over 50% of these girls will have abortions before the age of 20.

FIGURE 17

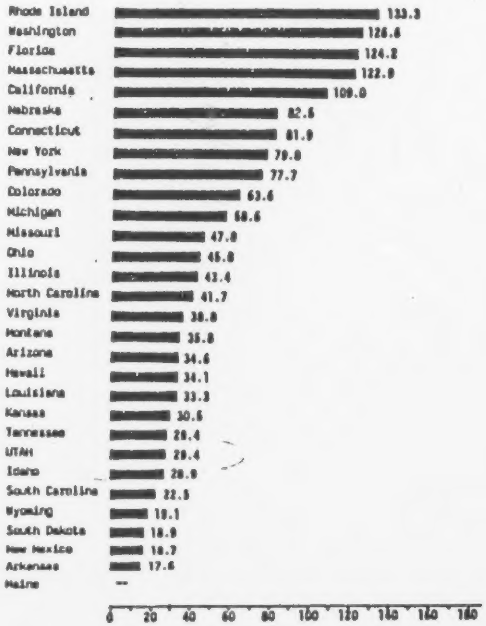
1980 INDUCED ABORTION RATES[1] FOR WHITE FEMALES 15-19 YEARS OLD IN RANK ORDER FOR RESPONDING STATES



[1] The number of induced abortions per 1,000 white females ages 15-19.

FIGURE 18

1980 INDUCED ABORTION RATES[1] FOR NONWHITE FEMALES 15-19 YEARS OLD IN RANK ORDER FOR RESPONDING STATES



[1] The number of induced abortions per 1,000 nonwhite females ages 15-19.

Senator **Denton**. Thank you, Senator Flamm. I suppose you are aware that I agree with you that it should be recognized as grotesque and the greatest overextension of governmental reach for parents to be excluded from counsel which may or may not, and usually does not, conform to the parents' values respecting sexual activity and sexuality.

From what I have seen, most large title X grantees give no consideration to the parents. There is language in the 1981 title X law which says that parents are to be encouraged to participate, or words to that effect. I have yet to be assured that activity to match those words is taking place, and there seems to be a united, vast majority opinion among family planning providers that there should not be.

I think that they should change their minds; I hope they do. I believe the American public is going to change their minds for them, and I believe possibly with a number of lawsuits which might be quite punitive financially.

In the meantime, what is possible here in the Congress is a good question. The perceptions of the average Senator and the average House Member of family planning is either nonexistent or coincides with that which you mentioned. They see title X as something that affects the poor or married couples, or, perhaps, may have something to do with overpopulation in India, not recognizing that a large percentage of the services are provided to unmarried young people whose parents are excluded at a time when they certainly should be included in the process and permitted to know what is being said and done with their child.

That is a rather clumsy statement of my belief, but I agree with the thrust of what you said. You indicate here that before Senate bill 3 in Utah, the annual yearly rates of increase were 5, 10, and 4.4 percent, respectively, for pregnancies, abortions, and live births. That is an increase every year.

You indicated that Utah required parental consent and notification and that a court decision denied you title X funds. Did it also overturn the State's ability to require parental consent in your State-served facilities, or have you got enough money to do it without title X money?

Senator **Flamm**. We will probably do away with the services. The terrible thing is they not only took away the moneys for the teenagers, but they took away all title X family plan moneys for us to serve adult members, which were actually taking 60 to 70 percent of all the funds.

There are areas of the State which no one else could reach but our State health department, and those funds have been taken away, so that we cannot get out into the small areas. It might be fine in a large city to have some kind of a planning clinic, but what do you do out in places like St. George, UT, or Hiram, UT, or some of these places that are a long ways away that have no other facilities other than the State health department?

Senator **Denton**. Excuse me just a moment.

[Pause.]

Senator **Denton**. I want to be candid with you, Senator Flamm. In previous data—and I can see it is not the same data that I have received before—regarding the Utah experience in the year in which the law to which you refer was in effect, I was told that the data that I had received up to that point were not that valid, were not that well-based.

Now, I cannot determine that. That was what I was told, and in discretion, then, I did not emphasize the figures. I am told that these are different data. Would you go into any authenticity, any credibility that they might have? Could they stand close scrutiny?

I believe that this trend would take place. It is contrary to the general belief spread by the media that all teenaged girls are going to get pregnant and, if anything, become more sexually active because their parents are involved.

But I must be honest with myself respecting concrete data which are presented to indicate results which prove that, so could you discuss that for the subcommittee?

Senator **Flamm**. Yes. Here is "Teenage Pregnancy in Utah," a study by the Utah Department of Health from 1975 to 1981. I had them compile the figures for 1982 for me and I received those yesterday. I added them on in an extra column. I should have maybe given you a copy of this so that you could have the actual copies from the Utah Department of Health.

In this, they show the population in two segments between ages 15 and 17, and then 18 and 19. I asked them how they arrived at the figures between and they said, well, they indiscriminantly took the two and divided what they thought was the 15- to 17-year-old and the 18- and 19-year-olds.

Because of this, I took and on the large sheet here I added together all teenagers so that we would use all teenagers at the same time, so that I did not try to break it between the 15- and 17-year-olds and the 18- and 19-year-olds. I just took teenagers as a whole, added them together, so that you do have the statistics that are copied right off of this book.

You can see the numbers of teenagers, the pregnancies, in every single year starting with 1975–1982; the number of abortions and the abortion rates; and the live birth rate. Now, incidentally, although we had a 50-percent increase in abortions from 1975 to 1980, it is amazing that we still had an increase in live births at 22 percent.

Now, the statistics that are the most accurate are the number of pregnancies, the number of abortions and the number of live births. Those figures, they do have in the health department and they are very accurate.

And you can see that our population of teenagers grew and then in 1981, came down somewhat and then came back up again in 1982. Now, to make it comparable, I increased the population 3 percent and increased all the incidences 3 percent so that we would actually have a comparable number of clients that we were working with.

And so I increased for 1982 by 3 percent the number of teens. I increased the pregnancies by 3 percent, the abortions by 3 percent and the live births by 3 percent, so that in fact they are comparables.

Senator **Denton**. Well, certainly, when I say media, I do not refer to all media, but much of the national media has blatantly claimed that there would be an acceleration of the rate of all of these things were parental consent to be required.

At the very minimum, I would think you have established that that is not the case. In pair with that observation, there should be another one made, and that is the impression given which pervades, I think, in the Congress here that this parental notification and consent thing is unpopular, an unpopular idea because that is what the Washington Post says; that is what most of the TV commentators say. That is what is quoted either explicitly or implicitly when you engage another member in discussion about this.

And yet the only polls taken by Mr. Gallup indicate the opposite. The American public overall is in favor, and it is most overwhelmingly in favor in the age group of adults old enough to have teenage children.

So we are operating with some misconceptions and those misconceptions might indeed exist within the family planning community itself. I hope that notice is taken of the poll—it was a valid poll—and notice is taken of these statistics. And if they are subject to question, I would like to see how it can be proven that there was an acceleration in Utah as was predicted.

I want to make sure I have got one thing straight that the ranking you had in Utah as being No. 3 in the Nation—that corresponds to these same figures that you have here. Utah's pregnancy rate was third in the Nation—that figure was in Senator Hatch's remarks, and now do you happen to know where you are ranked in the Nation? You have it second to last, I believe, in one of your charts.

Senator FLAMM. In the chart, this is the induced abortions.

Senator DENTON. Yes, that is true.

Senator FLAMM. And you must remember that we have——

Senator DENTON. Where did you rank in abortions before that?

Senator FLAMM. Our abortion rate has gone down just a little bit the last 2 years, but it did increase 50 percent from 1975 to 1980, prior to the legislation.

Senator DENTON. 1975–1980, an average of 10 percent a year?

Senator FLAMM. That is right.

Senator DENTON. And then it dropped by how much?

Senator FLAMM. Then it dropped 6 percent in the next 2 years, or 3 percent per year. Incidentally, when we were talking about Senate bill 3, about its passage, we were told all kinds of horrible things of what was going to happen.

We were going to have an absolute explosion in teenage pregnancies, abortions; the birth rate was going to go crazy. In fact, the opposite is happening. If you are going to look at a theory and say, what theory should we look at—now, the theory of family planning was that family planning was going to decrease all of these things—the live births, the abortions, and the teenage pregnancies.

In fact, it did not. It increased them in Utah from 22 to 50 percent during that 5-year period. Now, 2 years really is not enough time to know what is happening. On the live births, where it takes 9 months, and the law went into effect in May 1981, we could not really even look at 1981.

The only thing we can look at is abortions because that was the only thing that you can know of in 1981. But in 1982, the statistics were not released until yesterday and I put an awful lot of pressure on to have those figures so that I could bring the 1982 figures here.

We had assumed that there had been a decrease, or there would have been a great publication by some of those who want to promote this ideology of nonparental consent and let them have whatever they want; do not tell the parents.

Senator DENTON. Well, in accordance with Parkinson's law and free enterprise, it would appear to benefit those in the industry if one can keep selling the idea that with more illegitimate births, or abortions, the more the industry needs Federal funds. And the question is, is that throwing gasoline on the fire?

I hope that you will keep us informed of additional data as your State health department produces statistics regarding 1983.

Senator FLAMM. Because of the financial rewards for providing these services, I would like to read a little statement that came from the Planned Parenthood East Side Clinic in Colorado Springs.

It says,

> Refer a new patient and get a free package of birth control pills. Each new patient making an appointment and keeping it will be asked at the time of registering who referred her to this clinic. If she was referred by a current Planned Parenthood patient, a coupon will be clipped in the current patient's chart and she will automatically receive one free package of birth control pills on her next supply visit. If you like our services, refer a friend or friends and get a free package of pills for each one who becomes a new patient.

Now, that is adults or children. Usually, the younger people would not be paying, but adults would be. So this would be encouraging adults to bring people to their clinic because it is profitable. And anytime there is a profit motive, that is when selling takes place.

Senator DENTON. Yes, it does seem to test altruism as a motive of Planned Parenthood, for example, when I recently read one of their newsletters in which they said they were planning to go into the business of manufacturing and selling their own condoms.

That does not quite seem to fit with the public service devotion of a social worker. As you say, the profit motive appears to have become involved.

As a State senator, have you or any of your colleagues found indications that other States might be interested in passing measures similar to yours?

Senator FLAMM. We have been contacted by several other States. They are watching us; we know that. But we happen to be the only State that passed legislation because of that big cloud hanging over that you will not only lose your title X, but maybe title XIX, maybe some title XX funds.

Because of that big cloud, we were the only ones that had the courage to stick our necks out and take the chance. We are grateful now that we did it, even though we have lost our funding and $500,000 a year has been taken away from the State. Not just for the teenagers, but all family planning moneys under title X have now been taken away and given to Planned Parenthood and a small clinic up in Park City.

And so they now are supposedly furnishing all of the services for family planning under title X in the entire State of Utah.

Senator **Denton**. Well, liberals and conservatives, Democrats and Republicans, black and white, all sectors of our society recognize the emergency proportions of the problem. One can think about the financial cost; one can think about the unhappiness of little children being born into the world or aborted from the world, they are alive when they are aborted, the unhappiness of the teenage parents who find themselves unable to properly care for them, or at least care for them in circumstances far from ideal, the not inconsiderable inconvenience, expense and trauma involved of the parents of the young mother; the citizenship effect a generation from that time when the little child becomes an adult—those are incalculable costs, so I agree with all of those that there is a problem.

I believe that it would be better were this problem handled at the family level, we do have a great many family break-ups going on now; we have an unprecedented development there which may not be disassociated from the same philosophical criteria from which many are departing in approaching this problem.

It is imperative that we look at the causes and effects of the breakdown of the family, which we have done in five hearings or so. And I hope that we can all work toward the promotion of the general welfare in this problem and resolve our disagreements to a greater degree than we have so far.

There are many in the family planning community who are beginning on their own—and I do not take any condescending credit for this because I am not either omniscient or interested in imposing my beliefs—but there are many in the family planning community who are coming around to the belief that "no is the best answer" might not be a bad approach to the problem, which would not be shocking to our Founding Fathers or, you know, to the national principles upon which the Nation has based its entire legal and judicial system; indeed, its whole political philosophy.

"All men are created equal, they are endowed by their creator with certain inalienable rights." Along with that view goes a code of ethics which we cannot even talk about and receive funding. You are going to hear later from a group that accepts the fact that they cannot receive any Government money because they are telling it like it is.

Now, I wonder if there are a number of interested people in Utah—not that you should not continue to fight the battle that you are—but in the meantime, should you give up or can you get voluntary sources to work on this problem in another manner? That is a question I ask you as a State Senator.

Moreover, some are worried that the provision of an exception to the regulations in the title X program could create a bad precedent with respect to other Federal laws that some States find objectionable. Are there any unique reasons why the Federal Government should give ground on the question of parental involvement in this area?

Senator **Flamm**. Well, of course, the reason I feel that they should give ground is because how can you compare? When someone comes up with a theory—I do not care what the theory is—and they want to test it, how can you compare whether it was the right thing?

A trend may make it so that if everyone is doing the same thing, you cannot tell. But if you allow various States to experiment and then compare, and you notice some States dramatically bucking a trend, then you might ask yourself, is Johnny out of step?

It is like the mother that sees a group of soldiers marching down the way and one is out of step and she says, look at all those soldiers out of step except my boy, Johnny.

Senator **Denton**. In a democracy, we have the anomaly, I think, in this area of a minority controlling the action in this tragically important field, and I do not know how long that is going to persist.

I will read some statutory language that could possibly address the problem that Utah faces and ask your response to it. "Notwithstanding any other provision of this title or of any other law, no State agency may be denied funds under this title because the provisions of any State law governing the provision of family planning services and supplies to unemancipated minors within the State are more stringent than the requirements established by this title for the provision of family planning services and supplies to unemancipated minors."

I think that those words were composed by Senator Hatch and he intends to try to have them made applicable by law.

Senator **Flamm**. I have read them very carefully. I think that that would solve the problem for the State of Utah, and I think that you would find many States jumping on the bandwagon and saying, we cannot do any worse than the present legislation; let us give it a try.

Senator **Denton**. We do have one alternative program, called the Adolescent Family Life Act, which I introduced and was successful in getting passed, with bipartisan support, unanimously from the Labor and Human Resources Committee, which is not exactly the most conservative committee in the Senate.

It did represent to me the only thing I could do. I tried the waters; there was no way to change title X at that time. The waters may be of a different temperature and tide now, but at least it offers the approach, as you probably are aware, of not using the "push them into it and then give me the money to pay for the contraceptives and the abortions, and so on," and that will take care of the problem.

It does not even mention abortion; it does not even mention contraceptives. If the girl comes in there, she is going to be given counseling which would tend to emphasize the advisability of delaying until she is married, which seems to be a novel suggestion these days.

If that girl does not like it, she has a free will; she can walk across the street to a title X clinic and receive contraceptives. So we ought to keep that in mind, but it does offer at least one alternative and I hope you support that alternative because it was the only thing I could come up with at the time, legislatively.

Are you aware of that act?

Senator **Flamm**. I am. I do not think it will allow us to continue under Senate bill 3, however.

Senator **Denton**. No; and I know that is a separate issue and one which should be pursued in parallel. But in the meantime, we at least have that in place. Suit has been brought against it by the ACLU for the same reasons that your State law was attacked, so I hope you will give your support to that Act.

Senator **Flamm**. I would think that if the committee could adopt a stand in which they said that if funds were withdrawn it would only be the funds to the teenage group, the State still is best able to serve the adult population in family planning.

But to have all of our title X funds taken, not just those that have to do with the teenagers, seems like a rather—well, it is like saying if you grab the cookie, I am going to cut your arm off at the elbow.

Senator **Denton**. Well, you do not mean you would concede leaving the teenagers to the fate——

Senator **Flamm**. No; I just think that they ought not fund it, period. I think they ought to cut down our deficit. If they are not going to let us do it our way, for goodness sake, do not go around our back and give it to someone else to do what we do not want done in our State.

It is bad enough for us not to have funds to do it the right way, but to take them away from us and give them to somebody else and say, you are bad, bad boys because you are trying to do it your way—we are going to take away all the money, and not only are we going to take it away; we are going to give it to somebody else to do it the way Big Brother thinks it ought to be done.

Big Brother sometimes does not make the right decisions on budgets, on deficits, and a few other things.

Senator **Denton**. Big Brother turns out to be more Congress than the President. The President has written things which indicate to the contrary. As you know, the Department of Health and Human Services tried another approach, which a Federal judge overruled with the great assistance and urging on of the ACLU and the family planning industry, per se.

So there is sort of a political war going on. It is not as it was 5 years ago when nothing was being done.

Senator **Flamm**. It would appear to me that Judge Winter in his ruling ignored what the Supreme Court had said of parental responsibility, and instead took the intent of Congress, just like you said. He took the title X legislation and overrode, because of that, all of the constitutional provisions of parental rights to teaching morality and religion to their children without Government interference.

And we feel badly about it and we very well may take it to a higher court and test this case further.

Senator **Denton**. Well, may I suggest that you send these statistics which you gave me to the rest of my Senatorial colleagues, not just to members of the full committee, the subcommittee, or to whomever you submitted them, because we desperately need a raising of the level of understanding of this issue?

I think that human beings can come to the best solution once the problem is addressed. I see change on both sides. I have had to revise some of my own ideas. I have been into this for about 10 years now, and I thought first it ought to be left to the parents entirely and then you have to face the fact that maybe the parents do not do it that well, so you invite doctors to participate and perhaps some whose values correspond to the parents', and work on it that way.

But my hurting point is when the little girl is at the point of decision, she is being advised by one side; the parents are not permitted into it. That seems to me a hideous development in this Government.

Senator **Flamm**. It sure seems wrong to me, and most parents do not realize that their little daughter, age 13 or 14, may be thinking along these lines. And experience has shown me that many of these teenage girls become sexually active at age 14; some younger, some just a little bit older.

But this is very common for a 14-year-old to become sexually active, sometimes with older boys.

Senator **Denton**. We received statistics at our last hearing, I think, to the effect that in Baltimore I believe 50 percent of the seventh graders are sexually active. An argument can be made, then, that someone needs to help these adolescents other than their parents because apparently their parents are there and nothing effective is happening.

And we must agree before we finish that there are many other factors impacting on the rate of increase of earlier and earlier exercise of the full sexual powers of these youngsters—the movies, television; the magazine literature; the songs; the drug cult, with that often going on hand-in-hand with early sexual activity.

So there is no one villain in this, but we need to improve the situation.

Senator **Flamm**. As I have been sitting here, I just thought that there is nothing against the State sending out a letter like I gave you; having all the schools send it on out and asking parents when their daughters are 12 or 13 years old for this right to give this information. It might wake a few parents up.

If that happened, it would be worthwhile, so I think I am going to try and encourage that in the State of Utah that this type of a letter go out to all parents of a 13-, 14- or 15-year-old daughter, asking for their consent, and just see what kind of a reaction we get. It might be very interesting.

Senator **Denton**. Well, it is a wild comparison when we have laws requiring that the schoolteachers get written permission from the parents to prescribe a couple of aspirin and do not have to get any permission at all to counsel regarding the decisions of this girl that affect the rest of her life, the rest of the life of her baby, the rest of the life of her sexual partner, the rest of the life of her parents.

They can issue her an IUD or whatever they want and perhaps not give her proper instructions, aside from any values that are involved here. So it is an anomalous situation.

Thank you very much, Senator Flamm, and I hope you will stay in touch with us regarding any further statistical base you develop on this.

Senator **Flamm**. I will. The sad part of it is we have been cut off in the middle of the year, and if 1984 goes up now, and especially if it starts that same climb that we had prior to SB 3, it would maybe kind of be a sad state of affairs.

If it goes back to its same ratio, we will have hundreds of girls affected, more than are being affected right now, in the State of Utah.

Senator **Denton**. Well, I do not see why you do not appeal because HHS made the regulation regarding parental consent and notification. After much soul-searching, when I looked into the title X language which contained words to the effect that parental involvement is encouraged—when I looked at the Adolescent Family Life Act and saw what it said about parental involvement, it is proper for the Supreme Court to judge what Congressional mandate has been given to a governmental department.

The Federal Government decided not to appeal that case. At least I can see some justification in not appealing because a Federal agency is supposed to do what Congress mandates and they felt that there was not a sufficient mandate.

But for a State or a city or a neighborhood or a parent to say what they will do toward that child, it seems to me, by the separation of powers and the lack of Federal Government jurisdiction over those things, except those which were explicitly given it, you should be able to make your own laws. I do not see why you do not appeal.

Senator **Flamm**. You probably heard of the man in Denver that found out they had aborted his daughter, walked on in and said, you had better call the police because I am going to wreck this place. He took a chair through their plate glass window, busted out the doors, and said, you had better call the police, and he said, you had better file charges because if I get out tomorrow, I am coming back and doing it all over again.

So he is right now sitting in jail waiting to be able to test this case of whether or not a parent should have been notified. I just think they are very lucky he did not come in with a shotgun, shooting.

Senator **Denton**. Well, there are many more cases and that is what I meant about the lawsuits. Thank you very much, Senator.

Senator **Flamm**. Thank you for having me.

Senator **Denton**. Our next witness is Dr. Frank Bonati, who is the director of the Family Health Council of Western Pennsylvania. Dr. Bonati is also a board member of the National Family Planning and Reproductive Health Association, NFPRHA.

Dr. Bonati, welcome. We recognize your experience in this field and we are looking forward to your testimony, as well as any statement you care to make at this time.

STATEMENT OF FRANK A. BONATI, EXECUTIVE DIRECTOR, FAMILY HEALTH COUNCIL OF WESTERN PENNSYLVANIA, INC., PITTSBURGH, PA

Dr. **Bonati**. Thank you, Mr. Chairman. By way of introduction, perhaps I should state that the Family Health Council of Western Pennsylvania, Inc., is a private, nonprofit corporation operating out of Pittsburgh, serving the western part of the State.

We have been a title X grantee since 1971, and since that time we have gone on to develop other types of maternal and child health care services. Most recently, we are fairly pleased in the licensing of our agency as an adoption agency in the Commonwealth, and I think that probably makes us the only title X grantee that is also an adoption agency in the country.

Senator **Denton**. Before I forget, I would like to strongly commend you for that, sir.

Dr. **Bonati**. Thank you, Senator.

I would like to address the subcommittee today in terms of reauthorization of title X of the Public Health Services Act, and address my comments to two specific areas, the first being that of infertility.

And for purposes of my testimony, just a brief definition of infertility, and I think that most specialists tend to agree with the American Infertility Society's definition, and that is that it is a status that exists when pregnancy has not occurred after 1 year of regular sexual relations without contraception.

It is not a rare problem, sir. It affects some 10 million persons in the United States alone, 15 to 20 percent of the population. And it is not an easy situation to live with for infertile couples. It is considered a life crisis. It is considered a developmental crisis.

Most often, the couples feel somewhat out of control of the situation, somewhat at a loss. I think that the title X funded family planning community has an opportunity now to ameliorate some of the problems associated with infertility.

What I would suggest is the consideration that we look at title X grantees who have a responsibility for a cluster of family planning clinics in their service area. Virtually every clinic in the network can provide a certain level of care for infertile persons.

All of them are capable, or could be made capable, of providing information on fertility awareness, education, and certain basic types of laboratory tests, for that matter. Selected clinics within the cluster geographically could be targeted and provide even more sophisticated work-ups for infertile persons—semen analysis, postcoital testing, even certain endometrial biopsies, for that matter.

Beyond that, of course, if we are dealing with infertility, you are talking about sophisticated, usually in-hospital types of treatment—surgical intervention, some more indepth social/psychological type of counseling.

To that extent, though, title X-funded clinics could serve as referral bases. They could do the followup; they could see that people do not get lost in the system. Furthermore, the National Institutes of Health now fund any number of clinical and applied research projects across the country that deal with infertility.

Title X grantees are, first and foremost, meant to be management organizations, and as such I think they could be used as conduits for this funding purpose, thereby they could bring to weight, I believe, the full intent of Congress in dealing with the problem of infertility. It is a more cost effective approach and I think it would allow for more timely use of research findings in actual clinical settings.

In summation, with regard to infertility, I think we need a certain foundation and infrastructure with which to build upon. I think the contraceptive care clinics have the capability of providing that.

Infertility services are costly. Accessibility is a problem. The title X family planning network, I think, provides us with a certain mechanism that we can contain those costs, possibly, and make these services available to many families who otherwise would not be able to take advantage of them.

The second title X service that I would like to address here this morning is that of pregnancy testing and counseling. Current title X regulations require grantees to provide nondirective counseling and referral to pregnant women on one of the following alternative courses of action: pre-natal care and delivery, infant care, foster care, adoption, or pregnancy termination.

Unfortunately, very little guidance is proffered by the regulations on exactly how that counseling is to be done. I would suggest a certain clarification of the counselor's role and responsibilities.

To begin with, and technically speaking, it is not nondirective counseling that we should be instructing the counselors to do out there in the clinics. We rather should be asking them to perform decisionmaking counseling in which nondirective techniques are employed. Let me briefly explain.

It is the purpose of decisionmaking counseling to assist the pregnant woman in arriving at a decision. It is a decision that is the best possible one for her to make, given her own value system, and not one which the counselor thinks is best, based upon her or his value system.

Thus, it is nondirective, but it is not a passive process; that is, the counselor does have an active role to play in the process. It is not merely a laying-out of the options and then walking away. Rather, it is an obligation that the counselor has to uphold the integrity of that decisionmaking process itself so that the client's choice is a valid one and one which she respects.

Accordingly, I would suggest that the decisionmaking counselor in a family planning clinic must do the following: first, explain to the pregnant woman the nature and the purpose of the counseling itself to be given; second, ensure that the client is aware of all the options that are available; third, have sufficient knowledge of all these options and be able to explain each option, be able to explain its consequences; rely upon printed material.

I think too many of our counselors tend to rely on memory and not detailed information itself that is available in print.

Fourth, help the client in assimilating the most relevant of the information in the client's subsequent analysis and the choice the client makes. There is a ton of information. I think the counselor has a role to help the client sort out the most relevant of all the data that we know to be available.

Fifth, advise against impulsive decisionmaking or decisionmaking that is made under psychological stress or peer pressures; avoid biased questioning. Finally, I think the counselor must provide referral information once a choice is made so that the client can take the action necessary to, in effect, terminate that counseling relationship.

In the interests of time, perhaps I will conclude here. More detail, of course, is provided in the statement.

Senator **Denton**. Thank you, Dr. Bonati. Your full written testimony will be submitted for inclusion in the record, without objection.

[The prepared statement of Dr. Bonati follows:]

TESTIMONY OF

FRANK A. BONATI, ACSW, DR.PH

EXECUTIVE DIRECTOR

FAMILY HEALTH COUNCIL OF WESTERN PENNSYLVANIA, INC.

BEFORE THE

LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES

UNITED STATES SENATE

MAY 1, 1984

Family Health Council of
Western Pennsylvania, Inc.
625 Stanwix Street
Pittsburgh, Pennsylvania 15222

My name is Frank A. Bonati and I am Executive Director of the Family Health Council of Western Pennsylvania, Inc., an organization which has been a Title X grantee since 1971.

We have been involved in a variety of services and programs centered around gynecological and reproductive health, as well as human services concerning family issues. For example, the Family Health Council carried out one of the first demonstration projects to coordinate infertility services on a region-wide basis for the Department of Health and Human Services.

In addition, to my knowledge, our organization is the only Title X grantee in the United States that also provides state licensed adoption services for infertile couples.

Mr. Chairman, I appreciate the opportunity to testify before this subcommittee concerning the reauthorization of Title X of the Public Health Service Act.

I would like to address my comments to just two specific services made available under this important legislation. The first issue deals with infertility services.

For purposes of my testimony, it may be helpful to establish a working definition of the word "infertility". Unlike the specific diagnosis of a disease, infertility refers to a health status that is variable and dependent. It is a function of degree and time in relation to a man and woman's ability to produce a child - their ability to be fertile. Most specialists tend to accept the American Infertility Society definition of infertility as the status that exists ". . . when pregnancy has not occurred after a year of regular sexual relations without contraception" or, one might add, the inability to carry a pregnancy to term without a live birth.

Infertility is not rare. It is a significant problem which affects between an estimated fifteen and twenty percent of the population of childbearing age - over ten million persons in the United States alone, and there is some evidence that the problem is increasing. Infertility problems are not confined to one sex nor to any particular group. It is not a sexual disorder nor necessarily a constant condition - that is, infertility is a situation that can change since it can happen to persons who were previously fertile.

For most couples, infertility is not an easy thing to live with. It is classified as a life crisis or developmental crisis. The common feelings that may accompany the recognition of infertility are surprise, denial, isolation, feelings of anger, guilt, unworthiness, depression and grief. Quite often, the couple feels out of control of the situation and without options.

The Title X funded family planning community has the potential to meaningfully contribute to the amelioration of this problem.

When Title X was first reauthorized in 1975, Section 1001 was written to read that voluntary family planning projects "shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)". The subsequent 1978 and 1981 reauthorizations continued to include infertility as a viable Title X program component. Thus, the family planning movement had evolved to encompass all aspects of fertility, not only prevention of contraception, but also the provisions of services to persons who wanted to achieve pregnancy. While the title X program has had a justifiable emphasis on contraceptive care, the family planning clinic network makes it a logical benchmark for moving into areas of dealing with the problems of infertility. For example:

- Like contraception, infertility is a complex problem in reproductive health care - that is, in approximately 40% of cases investigated, infertility is due to male factors, 40% to female and 20% to unknown causes.

- Like contraception, infertility requires a multi-disciplinary approach in patient management: input from gynecology, urology, reproductive physiology and social work. There are many causes of this problem and many different methods of treatment.

- Like contraception, there is a noticeable role for counseling of the couple in the provision of a high quality service. There are certain psycho-dynamics that come into play impacting upon reproductive functioning and the very emotional well-being of the patients themselves.

- Finally, the natural family planning method of contraception, in particular, requires intensive patient participation in and provider knowledge of fertility.

The point is that in terms of program operation, the family planning network is an appropriate building block for entree' into a sub-system of infertility care.

Title X funded systems have the campability (and in many areas across the country this already exists) of managing a sub-system that has the following dimensions:

Level One

Information, fertility awareness, education, minor laboratory testing (hemoglobin or hematocrit, PAP smear, G.C. Culture) counseling and referral, if necessary

Level Two (at strategically located clinics)

Semen analysis (mobility, density and sperm morphology); postcoital testing and endometrial biopsy

Level Three

Referral and follow-up for the most sophisticated, usually in-hospital, surgical interventions and intensive socio/psychological counseling services.

Title X grantees also have the potential of enhancing their linkages with major educational research institutions. For example, the National Institutes of Health (NIH) now funds any number of clinical and applied research projects dealing with infertility. Title X grantees, as management organizations, could be used as conduits for these funds, thereby bringing to bear the full weight of congressional intent in dealing with this problem . . . a more cost effective approach which would allow for the more timely use of research findings in real clinical settings. This overwhelming ability of the Title X system to immediately utilize knowledge gained in NIH funded research is perhaps our greatest potential economic and programmatic opportunity.

All of the aforementioned is well within our grasp. Much of the work began in 1980 when the Bureau of Community Health Services allocated "Special Initiative Monies" over and above modestly needed increases in contraceptive care dollars. With subsequent budget cuts though, we have lost much of that headstart. Without adequate contraceptive care funding, we cannot begin to realistically deal with infertility. We need the foundation and infrastructure that our contraceptive care clinics provide. Infertility services are costly and access is limited. The Title X family planning network provides us with the mechanism to contain costs and make these services available to many families who other wise could not take advantage of them.

The second Title X service that I would like to discuss is pregnancy testing and counseling. Much of the criticism of the national family planning program concerns this aspect of service. However, I feel we must keep in mind the total concept of family planning and not focus all our attention on a small portion of the whole. Family planning is the ability to postpone pregnancy through various contraceptive methods, and to plan for wanted children and their future well-being. As I have previously discussed, this also involves helping the infertile couples to have families.

This is the fundamental concept from which we view our work. Unfortunately, not every pregnancy is planned. Please keep in mind that the acceptance of any Title X funded family planning service is strictly voluntary. This is especially true of the information received in pregnancy counseling. It must also be remembered that when a person enters a family planning facility, that person is entering a preventive health care system. Professional and ethical standards of health care mandate that information be shared with that patient. Counseling performed in these family planning clinics is not abortion counseling, nor is it abortion advocacy.

Current Title X regulations require grantees to provide non-directive counseling and referral (upon request) to pregnant women on the following alternative courses of action:

- prenatal care and delivery
- infant care, foster care or adoption
- pregnancy termination

While the aforementioned list of "options" is exhaustive, litle guidance is proffered by the regulations on exactly how such counseling is to be procedurally implemented. Family planning opponents are often not convinced of our objectivity and proponents often feel that our counselors do not have enough empathy with the client in crisis due to an unintended pregnancy.

I would suggest that a certain clarification of the counselor's role and responsibilities may help to lift this veil of suspicion.

To begin with, and technically speaking, it is not non-directive counseling that we should be directing the counselors to do in the family planning clinics, but rather decision-making counseling . . . in which non-directive techniques are employed. Pregnancy counseling does not and should not involve persuasion in any one particular direction or encourage one option over another. In this regard, and at the risk of oversimplification, there are only two distinct types of counseling to choose from: decision-making counseling or behavior counseling (psychotherapeutic or analytical). Between these two classifications of counseling, non-directive techniques are most intensely used in decision-making counseling.

It is the purpose of this decision-making counseling to assist pregnant women in arriving at a decision - a decision that is the best possible one for them to make given their own value system, and not one which the counselor thinks is best based upon her/his own values. Thus, it is non-directive, but not passive.

That is, the counselor does have an active role to play in the process, not merely a laying out of options to the pregnant woman, but rather an obligation to uphold the integrity of the decision making process itself so that the client's choice is valid and one which she respects.

The decision-making counselor (unlike the behavioral counselor) does not decide on the best option and show the client the way to that particular option, but rather works with the pregnant woman in prescribed, professional fashion which results in the client freely choosing what is best for her.

You may recall the old adage about the middle aged man unhappy with his job who states that "Here I am stuck with a miserable career chosen for me by an uninformed 19 year old boy." This, too, was perhaps a result of non-directive counseling but well may not have happened with good decision-making counseling. Accordingly, the decision-making counselor must

1. Explain to the pregnant woman the nature and purpose of the counseling to be given - emphasizing that the counselor will not sit in moral judgement of the client's ultimate choice of option.

2. Assure that the client is aware of all the options.

3. Have sufficient knowledge of all the options and be able to explain each option and its most likely consequences; relying on printed material, not memory.

4. Help the client in assimilating the most relevant information for the client's subsequent analysis and choice.

5. Advise against impulsive decision making or decision making under psychological stress or peer pressures, while avoiding biased questioning.

6. Provide referral information, once a choice is made, so that the client can take action and terminate the counseling contract set in the beginning of the process.

Sometimes persons have expressed the opinion that family planning clinics have a built-in bias towards abortion and that this undoubtedly influences the counseling process. However, if anything, family planning counselors are biased towards the provision of sufficiently valid and reliable information to their clients and to do so in such a manner that allows a pregnant woman to make a choice with which she can live and defend.

In conclusion, I do strongly recommend reauthorization of Title X of the Public Health Service Act with such language as is necessary so as to include the authorization for the provision of services to infertile persons. This should be done with a real understanding that specialized infertility care must be built upon an existing, accessible preventive or primary care health system.

Thus, I suggest the following:

1. If the Title X service system is to be the foundation for such care, then it must be adequately funded so as to allow for the add on of infertility care.

2. A more cost effective coordination of all Federal efforts (both applied research and service provision) in addressing the problem of infertility may be efficiently done at the community level by involving the Title X grantee as a funding conduit - thereby making maximum use of its management role and substantial experience.

As for pregnancy counseling. I suggest the following:

1. To define the counseling to be performed in family planning clinics as "decision-making counseling", not simply as non-directive counseling.

2. Direct the U.S. Department of Health and Human Services to develop grant guidelines which procedurally explain those tenets of decision-making counseling which I have described earlier in my testimony.

3. Allow for adequate in-service training of counselors on locally determined techniques to be used in their adherence to these decision-making counseling procedures.

In infertility, the decision is now yours - to build upon a sound, accessible contraceptive care clinic network and help infertile persons have dearly wanted children or to whittle away at a system that has the potential of offering to them a new hope.

In pregnancy counseling, give family planning clinic staff your direction and faith or perpetuate hesitancy and suspicion.

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Senator DENTON. Dr. Bonati, you mentioned in your testimony that in 1980 the Bureau of Community Health Services allocated special initiative moneys that could be used to provide infertility services. The funds were later halted.

Now, in 1984, the DASPA has set aside moneys for national priorities again, including infertility services. Would you say that the start-again, stop-again, nature of these special initiatives significantly affect the provision of infertility services?

Dr. BONATI. There is no question that it takes time to gear up a system, sir, and, yes, I would. The problem has been that we get the green light and we get everybody geared up—and that does not happen overnight; sometimes that takes years of development—only to be told that the funds therefore are cut off.

We need the ability to plan into the future. Fluctuations in funding are disastrous. When the special initiative funds came down, we had already received a certain increase initially for contraceptive care. A new pot came for infertility; it was clearly an add-on, one that we began to work with.

Subsequent to that, all X funds were cut dramatically. We were told to mesh infertility special initiative funds with our ongoing program. Infertility is, as I said, an add-on piece. Now, whether you add it on to preventive care programs, like family planning, or primary care programs like the 330-funded centers—I happen to believe that the family planning is the most logical—but when you add that on, it is like anything else that is added on. The first thing to go, then, is, in essence, the icing, if you will, the add-on.

You maintain the infrastructure, and that is what happened. Many infertility services were cut back dramatically in order to make the clinic survive.

Senator DENTON. Thank you, sir. You referred to the provision of level two services, including semen analysis and post-coital testing, and recommended or inferred that they should be, and to some degree are provided in strategically located clinics.

Based upon the number of couples in need of such services, is there any way to determine what the ratio of level two clinics to potential patients should be in a medium-sized State, for example?

Dr. BONATI. I am sure there is, sir; I am sure there is. In western Pennsylvania, we had a clinic network of about 53 clinics, if you will. From among those 53 clinics, we had, and still have, six that are strategically located that serve as that secondary level of care.

Throughout the title X system you are going to find many teaching hospitals, many private, nonprofit corporations that are more than storefront clinic operations that certainly have capability. I think it is a bit of a juggling act.

Scientifically, we could arrive at a reasonable guess on the ratio of secondary clinics to primary clinics. Beyond that, it becomes a political question in terms of which clinics also then have the necessary resources, the back-up and the ability to move on to that level, but it is possible.

Senator DENTON. When you say that title X grantees should play a larger role in NIH-funded clinical and applied research projects that deal with infertility, do you mean that title X grantees should be used as sources for the data or act as research performers?

Dr. **Bonati**. Well, sir, I think there are any number of alternative roles for them to play that can get us talking to one another. For example, we do not even know necessarily what NIH-funded infertility research projects are going on in our service area. Just to know about them would be helpful.

Second, beyond that there are review and comment possibilities, roles that the councils can play in terms of participating in the review process and the comment process; actual research funds.

There have been cases across the country; in western Pennsylvania, for example, we did serve as a natural funding conduit for the Pittsburgh Catholic Diocese and the University of Pittsburgh when we did intensive research on a natural family planning method of contraception.

The funds actually went from the Federal Government to us, just like the title X funds do. We then distributed them to the actual research providers. Now, the benefit of that was that it kept us in control, in a management control situation, a quality of care control situation. We knew what was going on.

The biggest benefit in any research project is being able to timely utilize the information, the knowledge that is garnered. And by being there, with the delivery system on the one hand and research information on the other hand, we were able to apply it very quickly. Couples therefore would have information available to them.

The infertility process is a lengthy process. You are talking about 6, 7 years of probing and exploring and intensive work-ups with couples, and time is everything to them; time is very, very important.

Senator **Denton**. Dr. Bonati, you make some good and, I believe, useful suggestions for clarifying the work of pregnancy counselors in family planning clinics. You suggest the adoption of decisionmaking counseling that is by its very nature nondirective.

As you outlined it, one of the goals of such counseling is to advise against impulsive decisionmaking or decisionmaking based upon stress or peer pressure. Should one of the goals of such counseling also include consideration of the parents 'ability to provide guidance, and the parents' point of view, for that matter—after all, they are their children—particularly when there is no evidence of parental abuse or neglect?

Dr. **Bonati**. I do not think there is any question that responsible counselors will be talking to pregnant women in crises, and naturally the younger the client, the more they will be, I think, responsible for involving the family, to the extent possible, especially, as you said, in the healthy social unit situations.

Unlike the prior testimony, we are not talking about counseling for someone who is trying to decide whether to become sexually active. You are talking about a person who is pregnant at this point in time—pregnancy counseling, if you will, which is kind of a misnomer. You are counseling a pregnant person.

There is a certain legal status of emancipation, as you well know, that a pregnant person achieves that has to be considered. There are in any counseling situation people that are important to the client, people that influence their decisionmaking.

And I think a responsible counselor would want to make sure that the client considers consequences of her choice, both negative and positive consequences. You cannot do that without talking to the client about those persons who influence their life, those persons who are a part of their life; no question about it.

In many cases, it will be the parents. In some cases, it will be a significant other person—a partner, a friend, an older relative.

Senator DENTON. How would you answer the question were it phrased in terms of prepregnancy counseling? In other words, the girl is not pregnant.

Dr. BONATI. Prepregnancy counseling? I am sorry.

Senator DENTON. Well, it is often called sexuality counseling. The girl is not yet pregnant.

Dr. BONATI. In terms of counseling a woman who is thinking about becoming sexually active or thinking about becoming pregnant?

Senator DENTON. Well, if they go into a title X clinic, for example, and they are not yet pregnant, I do not know what she is thinking about. But you mentioned again one of the goals of such counseling is to advise against impulsive decisionmaking or decisionmaking based upon stress or peer pressure. You mentioned nondirective counseling.

Again, I would ask, if this person is not pregnant or is not yet pregnant, should the counseling include consideration of the parents' ability to provide guidance, or at least to hear what is being said, particularly when there is no evidence of parental abuse or neglect?

Dr. BONATI. To the extent that a family planning clinic comes in contact with a person who is in need of that type of counseling, I do not think there is any question about it that the counseling should still have certain nondirective techniques.

And to the extent that the counselor adheres to some of those tenets that I oulined, I think that still holds true, and that includes encouraging the person to consider the significant others in their lives, including certainly their parents and other decisionmakers.

I say that I speak from the experience of our agency over the last 10 years, sir, and it is not anecdotal, but it is important to realize that at least 99 percent of the young women who come into our clinic are already sexually active.

At least 60 percent of them come in for a pregnancy test because they think they are pregnant. So they have already been sexually active for 4, sometimes 6 months, or whatever, and they are scared and that is the motivator for them coming to the clinic.

So it is very, very rare that a person walks into our clinic and says, hello, I am thinking about becoming sexually active; can we talk about it?

Senator DENTON. I would not expect her to say that, but nonetheless it is an important distinction. I want to get your meaning. When you say nondirective, you mean not necessarily to exclude direction from other important people or circumstances in her life?

Dr. BONATI. Absolutely; that is correct, sir.

Senator DENTON. Dr. Bonati, you have stated your organization is the only title X grantee in the United States that also provides State-licensed adoption services. Could you tell us about the genesis of that program and why the Family Health Council decided to provide adoption services?

Dr. BONATI. The adoption services are, of course, not title X-funded, but the genesis of it lies in our work with infertile persons. We began in 1980, using some of those demonstration Federal funds to look into infertility care.

As we were working with clients, we finally—and in the end, in working with any infertile couple, you get to the point where the couple has to make a choice between remaining childless or moving on to adoption and foster care. You have exhausted every medical intervention, every counseling intervention possible.

We got to that point with some of our clients, and quite frankly found the existing adoption system not responsive to their needs. When you are married and you are deciding when to have a family and you decide to try and have a family, you find out that it is not going to be as easy as you think; there is an age factor involved.

You may be 20-some years old at that point in time, and then you are faced with another 5, 6, 7 years of intervention, so now you are 30-some-years old and you finally have to face the fact that, well, what is open for me, just adoption?

At that point in time, adoption agency waiting lists, as you know, are extremely long. Many adoption agencies will not take you when you reach a certain age, over 35, or whatever. These clients were there with us. We thought, why not go the next logical step?

So we moved on to trying to proceed with adoption services, and that was pretty much the evolution of it. We are very pleased we did, incidentally.

Senator DENTON. In the provision of your services, aside from the infertile couples' consideration of adoption, how do you regard the counseling that might be given in terms of mentioning adoption as an alternative to the pregnant, unmarried young woman and the services appertaining thereto?

You are familiar with the fact that 20 years ago we had a very high percentage of children delivered by such young women placed for adoption, and now we have a high percentage kept to be raised by those women. So I would be interested in your comments on counseling regarding adoption to those who are unmarried and pregnant.

Dr. BONATI. Very good. Of course, we come into contact with the pregnant woman in a number of our service sites—family planning, the WIC nutrition program, and of course the adoption center itself.

In providing counseling to a pregnant woman, once again you have to be very careful in terms of making sure that you are not in any way applying pressure to the pregnant woman to force her to give her child up for adoption simply because you have an agency over here that has a lengthy waiting list.

Clearly, every effort must be taken once again in a nondirective way. The pregnant woman must be aware of the consequences; she must be aware of the options available to her. And in adoption, there are certain legal entanglements as well.

There are some elements of the adoption system, though, that I think can make it easier for a woman who is pregnant to sort out in her mind the consequences of her choice. For example, we have found that many of the young pregnant women do not react very positively to issues of foster care.

They do not like the idea that, upon delivery, their child is going to go into a foster care situation—a bassinet in a room with five other bassinets. And, you know, what is my child, in essence, going to have there? It is not going to have a loving home, if you will.

We also found out that pregnant women, and especially the younger pregnant women, react somewhat negatively to giving their child up to an institution, to an agency. They would much rather know that their child is going to a loving home straight from the hospital, if at all possible: my child is going to a family; my child is not going to this non-descript entity with all its bureaucratic redtape.

Now, of course, the counseling that is done varies from site to site, and when you are in the Family Planning Program the issue of adoption is laid out as an alternative along with prenatal care and along with foster care and along with pregnancy termination.

Counselors go through intensive educational processes—training, if you will—so that we answer their questions. One of the difficulties we have, I think, in the planning family network and in the WIC nutrition network and in some of our other more medically oriented services is that people are familiar with issues of human physiology so that they can speak fairly knowledgeably about carrying a pregnancy to term, prenatal care, and pregnancy termination.

But when you ask them to present the option of adoption, well, there is no scientific reference point for them to deal with. There are issues of paternal rights that have no application in reproductive physiology. There are issues of involuntary termination; you know, a ton of legal and social issues in the adoption field that are quite foreign to medical people and public health people many times. So there is an educational process that has to be followed.

Senator DENTON. Your agency appears to be unique in that you have counselors who are conscious of the adoption possibility because they are actually involved in adoption processes.

How could other family planning counselors learn more about adoption?

Dr. BONATI. There is no quick cure, in essence. I think that first of all, let me state that to the best of my knowledge family planning counselors do present the option of adoption. The problem becomes one of responding to client questions and inquiries and being as comfortable in talking about adoption as they are comfortable in talking about some of the other alternatives. So the option is presented.

I think we have to go beyond laying out the option. I think we have to provide the counselor with sufficient knowledge in order to explain issues related to adoption. And as I say, it is not easy. It is a question of, in the short run, certainly, training.

There are regionally funded title X training programs. There is no reason why the title X training programs cannot devote a significant amount of training time to counselors to deal with the option of adoption, to bring in specialists on adoption just like we bring specialists in on the counter-indications of low estrogen pills. I mean, we can bring a professional in to talk to counselors about the adoption option.

Training is a big thing. Reinforcement is a second issue. I think we have neglected counseling in family planning clinics until it became a political item. It never should have been. It always was part of the delivery system.

Now, in the early days of title X when there were few clinics and, in essence, some would think, therefore, more money to go around, counseling was an integral part. I mean, master's degree social workers and counselors were frequent in many clinics.

Especially with the funding cutbacks and with an emphasis on the provision of the medical care related to family planning, counseling has had to take a back seat, if you will. We have got to keep that clinic open. Well, you do not need a social worker to keep a clinic open; you need a nurse practitioner, a physician and a receptionist to keep a clinic open, and so I think it is a combination of things.

Certainly, we start with training. The second thing we do is acknowledge counseling as a full partner in the delivery system and give adequate resources to that end.

Senator **Denton**. Thank you very much, Dr. Bonati. Your testimony was most valuable. I appreciate your time. You might be receiving written questions from us and I hope you will respond to them as soon as you can.

Dr. **Bonati**. It would be my pleasure.

Senator **Denton**. Our final witness today is Mrs. Barbara Hammond. Mrs. Hammond is the director of the Crisis Pregnancy Ministry of the Christian Action Council.

Would you care to offer your statement, Mrs. Hammond, summarizing within 5 minutes if you can? If you do summarize, your entire statement will be included in the record as written.

STATEMENT OF BARBARA HAMMOND, COORDINATOR, CRISIS PREGNANCY CENTER MINISTRY, CHRISTIAN ACTION COUNCIL, WASHINGTON, DC

Mrs. **Hammond**. Thank you. Senator, I am Barbara Hammond. I am coordinator——

Senator **Denton**. Would you put the microphone closer to your mouth?

Mrs. **Hammond**. Yes.

Senator **Denton**. About the only way you can do that is put the paper to the side.

Mrs. Hammond. OK. How is that, better?

Senator **Denton**. Fine.

Mrs. **Hammond**. I am Barbara Hammond, the coordinator of the Crisis Pregnancy Center Ministry for the Christian Action Council. The Christian Action Council is an evangelical Protestant prolife organization.

Over the past 5 years we have developed a program which provides a much-needed alternative to the family planning clinics funded under title X. We instituted the Crisis Pregnancy Center program to offer a biblical alternative to the abortion mentality of the family planning industry.

Our concern is not just for the plight of the unborn child, but for the women who are being destroyed by the family planning providers. Previous to being employed by the Christian Action Council, I was director of the Greater Baltimore Crisis Pregnancy Center. For 2½ years I was there and I was able to observe the effects of federally funded family planning clinics on the women they are intended to serve.

I want to quote from a letter I received from a teenager who received services from one recipient of title X funds. This is just part of her letter. She says:

> People that have never experienced being pregnant and having an abortion would never know how much pain girls like us go through; it really hurts.
>
> The night I got back from Planned Parenthood, I called my best friend and was crying. I told her that I wanted my baby back. I saw the doctor throw my baby in a trash can, and that tore me up. Now I think my baby is piled under all kinds of trash.
>
> I wish now that I never had my abortion. My family and friends tell me to put the past behind me; forget about it. But I cannot. There is always that scar in my heart that my baby is dead. It hurts like hell.
>
> Before I had my abortion, I had a counselor talk to me. I was crying and told her that I did not want to have an abortion. Well, she went and got the head lady. She starts telling me that abortion is the best thing. I am only 15; I cannot support myself, and that since my baby is bi-racial, it would never be adopted.
>
> Well, here I am crying my head off and this bitch is telling me things that I do not want to hear, so what was I to do? I did not even know how to get out of there. It really hurts bad. Wherever I turn, I see things that remind me of my abortion.
>
> After my abortion, I went to this counseling center, but they could not help me, so here I am now. My baby was supposed to be born in June. I had my abortion on November 15th, on a Saturday. I wish that I could talk to somebody that had an abortion; maybe they could help me. I wish that I could have found out about your center; I could have come in and talked to somebody.

I have included this entire letter in the record. It ends with a fairly suicidal statement. And you may think that this is an isolated example, but unfortunately it is not. Many of the young women I spoke with at the Greater Baltimore Crisis Pregnancy Center were left physicially and/or emotionally scarred by abortion.

Frequently, they indicated that they had been pressured into aborting. Others reported being treated like cattle when they went in for contraceptive counseling. Tragically, these family planning clinics have dehumanized the very people they are supposed to help.

Our crisis pregnancy centers offer desirable alternatives to federally funded family planning programs. We have proven through this program that help can be made available to women without Federal funds.

Our first center opened in Baltimore in November 1980, and since that time we have trained volunteers who staff an additional 68 crisis pregnancy centers, 66 of which are in the United States. They are located in major cities, including Boston, Chicago, and San Francisco, as well as in smaller communities, towns of 2,000 or 3,000. We expect the number of these centers to double within the next year, possibly to triple.

None of these centers receive government funds; all are supported by individuals, churches, and civic groups in the local community, and a few have received grants from the private sector. Their annual budgets vary from $5,000 to $40,000; $25,000 to $30,000 is the usual budget.

They are staffed by volunteers, many of whom are medical professionals or counselors and several of them have physicians who are donating time. All of these volunteers are willing to give their time because they are believers in Jesus Christ, and therefore are committed to demonstrating Christian compassion to women in need, and I believe strongly that is why our program has worked.

The initial services that we offer are hotline counseling, free pregnancy testing, information about pregnancy, abortion, and alternatives. We do give abortion information.

The other thing is that 40 percent of the women that we see are not pregnant, and the majority of these women are single. With these women, we speak to them about being sexually active as single women. We approach them from a perspective that they are creatures created in God's image. They are not highly evolved animals incapable of controlling their sexual urges.

There was an article that appeared in a Baltimore paper, an editorial that asked, are teenagers more than rutting animals? And I feel that that is very often the way that they are seen.

Rather than pushing artificial contraceptives, we talk about sexuality with these women and we have had a tremendous success in getting them to choose abstinence. We also provide a lot of practical help and housing, and stuff like that. And we also have had a tremendous success rate in terms of getting women to choose to carry to term and to really just experience the joy of bringing a new life into the world.

Not one of the women that I have ever counseled has come back and said, why did you make me have this little brat, or anything like that. They have brought their baby in with tears of joy in their eyes because they are so excited about it.

I would just say that I feel that our program is a really good alternative to title X-funded programs; that we are offering information and alternatives that are not being offered by title X recipients.

[The prepared statement of Mrs. Hammond follows:]

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TESTIMONY OF BARBARA HAMMOND, COORDINATOR OF THE CRISIS PREGNANCY CENTER MINISTRY OF THE CHRISTIAN ACTION COUNCIL, BEFORE THE LABOR AND HUMAN RESOURCES SUBCOMMITTEE ON FAMILY AND HUMAN SERVICES

MAY 1, 1984

Mr. Chairman and members of the committee, I am Barbara Hammond, the Coordinator of the Crisis Pregnancy Ministry for the Christian Action Council. The Christian Action Council is an evangelical, Protestant pro-life organization. Over the past five years we have developed a program which provides a much needed alternative to the family planning clinics funded under Title X.

We instituted our Crisis Pregnancy Center program to offer a Biblical alternative to the abortion mentality of the family planning industry. Our concern is not just for the plight of the unborn child, but for the women who are being destroyed by the family planning providers. As director of the Greater Baltimore Crisis Pregnancy Center, I was able to observe the effects of federally funded family planning clinics on the women they are intended to serve. I would like to quote from a letter I received from a teenager who received "services" from one recipient of Title X funds.

> People that have never experienced being pregnant and having an abortion would never know how much pain girls like us go through. It really hurts. The night I got back from Planned Parenthood, I called my best friend and was crying. I told her that I wanted my baby back. I saw the doctor throw my baby in a trash can. And that tore me up. Now I think that my baby is piled under all kinds of trash.

> I wish now that I never had my abortion. My family and friends tell my to put the past behind me. Forget about it -- but I can't there is always that scar in my heart that my baby is dead. It hurts like hell.
>
> Before I had my abortion, I had a counselor talk to me. I was crying and told her that I didn't want to have an abortion. Well, she went and got the head lady. She starts telling me that abortion is the best thing. I'm only 15. I can't support myself and that since my baby is biracial it would never be adopted. Well, here I am, crying my head off and this b----- is telling me things that I don't want to hear. So what was I to do? I didn't even know how to get out of there.
>
> It really hurts bad. Wherever I turn I see things that remind me of my abortion. After my abortion I went to this counseling center, but they couldn't help me. So here I am now. My baby was supposed to be born in June. I had my abortion on November 15th, on a Saturday. I wish that I could talk to somebody that had an abortion. Maybe they could help me. I wish that I could have found out about your center. I could have come in and talked to somebody.

You may think that this is an isolated example, but unfortunately it is not. Many of the young women I spoke with at the Greater Baltimore Crisis Pregnancy Center were left physically and/or emotionally scarred by abortion. Frequently they indicated that they had been pressured into aborting. Others reported being treated like "cattle" when they went for contraceptive counseling. Tragically, these family planning clinics have dehumanized the very people they are supposed to help.

Crisis Pregnancy Centers offer a desirable alternative to federally funded family planning programs. We have proven that help can be made available to women without federal funds. Our first center opened in Baltimore in November of 1980. Since that time, the Christian Action Council has trained volunteers who staff 68 additional Crisis Pregnancy Centers, 66 of which are in the United States. They are located in major cities, including Boston, Chicago, and San Francisco, as well as in smaller communities. We expect the number of centers to double within the next year.

None of these centers receives government funds. All are supported by individuals, churches, and civic groups in the local community. A few have received grants from the private sector. Their annual budgets vary from $5000 to $40,000, depending upon the size of the population they serve. They are staffed by volunteers, many of whom are medical professionals or counselors. Several centers have physicians who are donating time voluntarily. All of these volunteers are willing to give of their time because they are believers in Jesus Christ and therefore are committed to demonstrating Christian compassion to women in need.

The initial services we offer are hotline counseling, free pregnancy testing, and information about pregnancy, abortion, and alternatives.

Forty percent of the women we see are not pregnant. The majority of these women are single. We offer them educational information and counseling about being sexually active. We approach these women as creatures created in God's image, not as highly evolved animals incapable of controlling their sexual urges. Rather than pushing artificial contraception, we discuss the nature of sexuality with these women.

They are grateful that we treat them as responsible human beings, capable of making mature decisions about their sexuality. Often they realize that engaging in sexual relations outside of the commitment of marriage is self-destructive behavior that puts them at risk. Thus Crisis Pregnancy Centers across the country have been effective in helping young, single women choose the most effective means of contraception available -- abstinence.

For women who are pregnant, we offer accurate information about all of the alternatives, enabling her to make an informed decision. We also provide practical assistance, including clothing and furnishings for her and her child. Housing is also provided, again through the willingness of volunteers to open their homes to women in need. Referrals are made for medical care, legal assistance, social services, and adoption. Classes in childbirth, parenting and other relevant subjects are offered.

Five out of every ten clients intend to abort when they first contact a CPC. After receiving our services, only two of those five actually abort. Thus we are enabling eight out of every ten clients to carry to term. So far, none of these women have regretted their decision to bring a child into the world. We have had young mothers come in to our centers with tears of joy in their eyes to thank us for the baby they are holding in their arms. I have had the joy of holding babies that would not be alive if it had not been for the ministry of a Crisis Pregnancy Center. At the Baltimore center one woman who came in to show us her newborn son said, "This is the baby that almost wasn't," as she held up a precious little boy with big brown eyes.

The Crisis Pregnancy Centers also offer post-abortion counseling for women who are emotionally distressed as a result of an abortion. In this role we are often dealing with the casualties of the abortion industry. I personally have talked to many women who are left traumitized by abortion. Often they suffer from nightmares, remorse, anxiety, or a desire to get pregnant again to replace the child they have lost.

One seventeen year old girl said, "It was a violation of my body worse than rape could ever be." Another teenager said, "I don't have nightmares, but I think about it every day," two years after her pregnancy was terminated by a Title X recipient. A woman in her twenties described her abortion as, "devastating." The most tragic cases were the young teenagers, thirteen or fourteen years old, who were given no choice at all. "They told me I had to have an abortion because I was too young to have a baby," one girl said of the family planning clinic she had gone to for help.

The family planning clinics funded by Title X seem to be operating under the assumption that the sole purpose of family planning is to limit the size of the human family, no matter what the cost. They offer little or no assistance when the plan includes the addition of new family members. Rarely are alternatives to abortion presented as a viable option. In contrast, the Crisis Pregnancy Centers are offering alternatives to enable women to plan constructively for their families. They are providing services such as free pregnancy testing, hotline counseling, and accurate abortion information. And they are doing it without federal funds. I offer this as evidence that there are positive alternatives to Title X family planning center.

WRITTEN MATERIAL SUBMITTED IN ADDITION TO VERBAL TESTIMONY
GIVEN BY BARBARA HAMMOND,
COORDINATOR OF THE CRISIS PREGNANCY CENTER MINISTRY
OF THE CHRISTIAN ACTION COUNCIL,
BEFORE THE LABOR AND HUMAN RESOURCES SUBCOMMITTEE
ON FAMILY AND HUMAN SERVICES
MAY 1, 1984

A LETTER TO PRO-LIFE CHRISTIANS

Dear Sir;

I agree with you 100% on abortions. But I had one. It was the hardest thing I ever had to do in my life. I'm gonna tell you straight about how I feel.

My boyfriend and I fell in love. We made love and I got pregnant. My mom noticed that I had skipped my period. I was taken to the doctor. He said I was about 6 weeks pregnant. So she said I had to have an abortion. My mother set up a date.

I had a counselor at Planned Parenthood who talked to me. She said my baby would never be adopted. Who was I to turn to? My mother and father didn't want me to have the child. I was forbidden to see my boyfriend, and the people at Planned Parenthood said my kid would never be adopted because of his/her race.

Would you mind telling me what you would have done? I didn't have a place to go, no money. Would you have taken me into your home? Paid my doctor bills and expenses?

My abortion is something that I wish I never had done. I can remember looking at the doctor when it was done and saw him putting my baby in a plastic bag and then throwing it away in a gargage bag. Do you know how bad that feels? Have you ever lost something you loved dearly? I did and I'm not proud of it.

I know there are girls that don't care about their babies. They would have 5 abortions a year and not worry about it. But I happened to care about my baby. If I had a place to go and people who cared about my baby and me, maybe my baby would be alive now. It was supposed to be born this month.

It hurts me so bad to hear things about abortions. I get really upset about things like that. You're hurting the girls who wanted their babies but didn't have any alternative but to have them aborted. But I want to say, "It hurts like hell."

I thank you for reading my letter. Please give it a thought. You people are against abortion, but are you willing to help young girls and women who don't have money or a place to live? I doubt it seriously. Some of us women/girls are not killers. We're humans too. And I can tell you that having an abortion is killing me slowly. Think about this please.

Thank you,
Beth

A LETTER FROM A GIRL WHO HAD AN ABORTION

Barbra,

Hi. Well this is Beth. I received your letter. I was happy to see that someone replied back to me. I thought that my letter would be thrown away and not read. I just wanted to tell you that I am against abortion. A lot of girls that get pregnant don't know who to turn to. I have two friends that had abortions, too. It doesn't seem to bother them with what they have been through.

People that have never experienced being pregnant and having an abortion would never know how much pain girls like us go through. It really hurts. The night I got back from Planned Parenthood, I called my best friend and was crying. I told her that I wanted my baby back. I saw the doctor throw my baby in a trash can. And that tore me up. Now I think that my baby is piled under all kinds of trash.

I wish now that I never had my abortion. My family and friends tell me to put the past behind me. Forget about it--but I can't. There is always that scar in my heart that my baby is dead. It hurts like hell.

Before I had my abortion, I had a counselor talk to me. I was crying and told her that I didn't want to have an abortion. Well, she went and got the head lady. She starts telling me that abortion is the best thing. I'm only 15. I can't support myself and that since my baby is biracial it would never be adopted. Well, here I am, crying my head off and this ------ is telling me things that I don't want to hear. So what was I supposed to do? I didn't even know how to get out of there.

It really hurts bad. Wherever I turn I see things that remind me of my abortion. After my abortion I went to this counseling center, but they couldn't help me. So here I am now. My baby was supposed to be born in June. I had my abortion November 15th, on a Saturday. I wish that I could talk to somebody that had an abortion. Maybe they could help me. I wish that I would have found out about your center. I could have come in and talked to somebody.

There hasn't been a day since my abortion that I haven't thought about it. I don't see how some girls can go and have 2 or 3 abortions and not think about it--what they are doing. I may be young, but I want to reach out to other girls who are pregnant or having sex and help them out. I wouldn't want anyone to go through the pain and suffering I'm going through now. It can tear a person in half. I feel like I am missing something in my life.

When you're in this situation you feel alone. There's nobody you can trust to help you out. People look down on you like you're trash. Do you understand how I feel? I wrote a poem about my baby. I want to see if you can understand.

One day, Baby, we'll be united in a world where no one can divide us
So don't you worry, Baby, I'll be along soon.
I didn't mean to do the thing I did to you.
So please forgive me, and always remember you're in my heart forever and ever.
This time nobody will rob you from your life, because I'll be there to protect you forever.

How does that sound? After I thought about my abortion for a while, I wanted to go back out and have sex with my ex-boyfriend to have my child back. But that would be dumb. It wouldn't be the same child. Well, I really appreciate you listening to me. Please keep in touch.

Yours,
Beth

COUNSELING THE SINGLE CLIENT WHO IS NOT PREGNANT

About 40% of the women who come into the Crisis Pregnancy Center will have a negative pregnancy test. They are not pregnant. Most of these women are single, and many of them are teenagers.

Their first reaction to news of a negative test is generally relief. Although they have avoided this immediate fear, the more fundamental problem has not been dealt with and needs attention.

At issue is a sexual lifestyle that holds forth destructive consequences -- medical, emotional, procreational, and spiritual -- which cannot be eradicated. It creates the possibility of pregnancy and a son or daughter. If a baby is conceived, the responsibility for another human being suddenly is thrust upon the single woman. At times this can seem overwhelming. Even among women who successfully cope, bearing a child alone and planning for his or her future is difficult and painful, whether or not the baby is released for adoption. Of course, an abortion always proves destructive at every level.

As a result of these consequences, the well-being of the client is at risk whenever she is sexually active outside of marriage. Although many women do not acknowledge that fornication is immoral, virtually all of them do experience some degree of ambivalence over their conduct. It isn't "safe" for them to be involved sexually, and they know it. Very frequently they are willing to discuss it; in fact they desperately want to discuss their sexuality.

Volunteer counselors at the CPC have a rare opportunity to minister to sexually active women. Because they've just had a "close call" with pregnancy, their feelings of ambivalence over their behavior are likely to be greater than usual. Often, they're teachable on the subject of their sexuality and open to changing their conduct.

Counselors should be prepared to minister to clients with negative pregnancy tests. The CPC exists to serve them as well. Although they are all sexually active and risk becoming pregnant, these clients may approach sexual activity from very different perspectives. The key factor is the extent to which they have been sexually involved. For purposes of ministry the clients can generally be classified in one of three categories.

Category I: Includes young women who have had relatively few sexual experiences. They are generally very concerned about their behavior and experience a variety of fears and insecurities about it. The client in this group is not sure that her behavior is good for her, but sexual involvement is seen as a way to solve a problem -- lack of love, loneliness, threatened loss of a boyfriend, desire for acceptance.

Category II: Includes the client who has been involved sexually for some time, one to two years. Although she understands and has access to contraceptives and contraceptive information, she still does not use them. This is true for the majority of unmarried teenagers during their first year or two of sexual activity. The reasons for their reluctance are related:

A. Teenagers tend to think that love is not authentic unless it is spontaneous. They justify having sex by claiming, "We love each other, and it just happened." They view intercourse as an uncontrollable and spontaneous expression of this love. Using contraceptives means planning sexual activity. This forces the teenager to face her responsibility for her sexuality. This makes her feel very uncomfortable, if not guilty. She prefers to avoid explicit decision-making regarding intercourse.

B. When a teenager begins using contraceptives, her approach to sexual activity and her identity change dramatically. She is passing through a threshold, moving away from being the young woman for whom sexual activity is not a planned, regular (and important) part of her life to being the woman for whom sexual activity is a significant part of her life. She is moving away from parental influence and authority, with whatever security these have afforded her. This loss of childhood dependence can be disconcerting. Thus many teenagers are hesitant to use contraceptives since it signals an irrevocable move into adulthood.

Category III: Includes the woman who has adopted a lifestyle of sexual activity. She may live with her boyfriend, or she may have relations on a casual basis. Often by this point in their lives, women have constructed a strong defense and rationale for their behavior. They may experience very little immediate guilt. Frequently this lifestyle comes in the aftermath of a failed marriage or a more traditional relationship that has ended in disappointment. Getting the client to re-evaluate her sexual activity may be difficult; on the other hand, the wonder of sex has been diminished for her, and she will tend to approach the subject in a practical and straightforward way. The key with this client may be for her to realize the need or void she is trying to fill with sex. Her sexual involvement may well be a "quick fix" for the despair she is trying to ward off.

How to Talk to the Client About Sexuality

At least four different strategies are open to counselors as they minister to clients with negative pregnancy tests.

I. Help the Client to Evaluate Her Sexual Activity

A. Within the context of her relationship to her boyfriend:

Sexual activity outside of marriage is destructive. When it takes place, the very purpose of a sexual relationship is being thwarted. Its effect is the very opposite of what God intends. Rather than drawing two people together into a relationship of total commitment, fornication becomes an end in itself, a substitute for communication. When sexual activity begins before a commitment has been made -- before love has come to fruition -- that love is thwarted. The dynamic of the relationship is transformed as the desire to give and share is replaced with grasping and taking. The God-given sexual drive is so powerful that unless it is constrained by selfless devotion to another, it becomes the dominant force in the relationship.

Counselors should help their clients realize the immediate risks and effect of being sexually active. A "preachy" style is inappropriate. Unless the client internalizes the truth about her relationship, the truth will have no impact. Through conversation the volunteer can help the client understand her situation. A good way to begin is by asking good questions:

1. Questions that deal with the immediate:
   a. How do you feel now that you've had a negative pregnancy test?
   b. How would you have felt if you had been pregnant?
   c. How do you think your boyfriend would feel if you were pregnant?
   d. What do you think your parents' reaction would have been to the news that you are pregnant?
   e. How do you think this close call will affect your relationship with your boyfriend?

2. Questions that deal directly with sexual activity:
   a. How do you feel about being sexually involved with your boyfriend?
   b. How important is sexual relations to you?
   c. Who first initiated intercourse in your relationship?
   d. A number of studies indicate that teenage women for the most part do not really enjoy intercourse, but that their participation is the result of pressure they feel. Would you say this description applies to you?
   e. On a scale of 1 to 10, how comfortable do you feel being sexually involved with your boyfriend? (Suppose the client responds with a 6.) Could you tell me the issues that fall between 7 and 10?
   f. What would be the effect on your relationship of sexual activity suddenly stopping?
   g. How do you think your boyfriend would react if you told him that you did not want to have sexual intercourse any more? (Very often, clients respond that the boyfriend would leave.) What do you think is the primary reason he is pursuing a relationship with you?

B. Within the context of her legitimate goals and aspirations:

Everyone has goals and aspirations that are legitimate. These are threatened whenever we engage in lawless activity. The client needs to recognize that her sexual involvement poses unnecessary risks to her future happiness and well-being. The volunteer should lead the client into a consideration of the other consequences of her sexual activity.

Many young people have great difficulty thinking through the consequences of their behavior. This unfortunate situation cannot simply be pinned to the notion that "kids are irresponsible." Many young people have never been taught to think in terms of cause and effect. Volunteers should encourage them to do so. This will be difficult, since many young people have no goals and ambitions. Again, asking good questions can instigate good discussion:

1. Questions that deal with the client's goals or hopes:
    a. What would you like to be doing in five years?
    b. Where would you like to be in five years?
    c. Of all the famous people you've ever read or heard about, who do you most want to be like? Why?
    d. If you could accomplish one thing with your life, what would it be?
    e. At the end of your life, what would you like people to say about you?

2. Questions dealing with the impact of the client's behavior on her goals:
    a. What risks does your relationship with John pose for your ambitions and dreams?
    b. What impact can a sexual relationship now have on your future plans?

3. As the client mentions risks, they should be explored, made specific and concrete. This will help her see there is no easy way out of the problems.

    a. Pregnancy could lead to:
        1. Early marriage
        2. Single parent family
        3. Abortion
        4. Adoption
        5. Difficulty in getting married in the future

    b. Venereal Disease could lead to:
        1. Severe discomfort and physical trauma
        2. Loss of self-esteem, severe anxiety, shame
        3. Sterility
        4. Incurability
        5. Transmission of disease to children during birth
        6. Difficulty in getting married in the future

    c. Breaking up: Any romance can come to a painful end. When the couple has been sexually involved, the emotional scars can last for a lifetime. The majority of teenage romances do end. The client needs to recognize this and anticipate the aftermath.
        1. Loss of self-esteem, shame
        2. Regret, bitterness
        3. Loss of reputation
        4. Difficulty attracting a man who respects her
        5. Cynicism and the loss of innocence

II. Discuss the Biblical View of Sexuality with the Client

A. The Nature of Sexuality

In contemporary America, the subject of sexual relations has been totally abstracted from reality. We see this in so many ways. Sex is used to sell everything from toothpaste to pantyhose though it has nothing to do with any of these things. Sex is treated in magazine articles and books as a form of entertainment, the highlight being the sensual pleasure of orgasm.

The Bible teaches that sexual intercourse is integral to our being as sexual creatures, male or female. Sexuality is a fact of our nature, and it determines our creativity as individuals. The highest expression of our creativity occurs in sexual relations for in this we can become co-creators of human life. Great care must be taken in exercising this power for we are responsible for the children we bear.

The Bible also reveals that sex is not a form of entertainment. It is a most profound means of communicating and expressing love. Two people are revealed to one another physically, emotionally, and spiritually as they are joined together in love. Love reaches its fullest expression in the creation of life itself.

B. The Nature of Marriage

Because our sexuality endows us with the potential to bring forth new life, and because sexual intimacy is intended as an unrestrained expression of love, only one relationship is fit for sexual intercourse -- marriage. No other relationship can support and sustain an individual who is expending so much of self and facing responsibility so awesome as that which inheres in sexual relations.

Most young adults today don't know what marriage is. They may think of it as a formal agreement to live together, or they see it as a public sanction on a sexual relationship. They may associate it with a ceremony or celebration. In fact marriage describes a relationship that is characterized by a covenant to live together and to serve one another in the sight of God till death. No lesser commitment can bring safety to the sexually involved man and woman.

C. The Nature of Love

The commitment of marriage is the commitment of love, selfless devotion to another. Love is endless; it is rooted in the character of the lover, not in the quality of the one being loved. Love is neither a feeling nor an ideal. It is an irrevocable commitment to another. In speaking with clients about the nature of love, the volunteer has an opportunity to speak of the one who etched in human history the definition of love that will last for all eternity, Jesus Christ.

Senator DENTON. Thank you, Mrs. Hammond. Would it be accurate to say that you and your colleagues volunteered to undertake the effort in which you are involved as sort of a counterforce to that which you see the government providing in the way of counseling in this area?

Mrs. HAMMOND. Definitely. We feel very strongly that title X is prejudiced because it insists that abortion referrals be made by groups. It has ended up basically funding a lot of abortion providers.

I have accepted referrals from title X recipients because they have nothing to offer a woman who carries to term. They do not offer assistance in terms of practical things—housing, baby clothes, maternity clothes, furniture, things like that.

The whole mentality is, unless you abort we are not going to help you; you have to get out there and help yourself. And if you are poor or if you are a teenager or whatever, then too bad; the only alternative is for you to abort. And we do not feel that that is fair.

Senator DENTON. You say that your approach regarding women who are not pregnant, the majority of them being single, is to offer them educational information and counseling about being sexually active. "We approach these women as creatures created in God's image, not as highly evolved animals incapable of controlling their sexual urges. Rather than pushing artificial contraception, we discuss the nature of sexuality with these women."

You are a Christian organization. I want to say for the record that on a flight from Denver to Houston about 1 week ago, I heard almost exactly these words from a man who did not know who I was or that I was a Senator or that I was even interested in this subject.

He raised the subject. He happened to be Jewish; he said almost precisely these words.

I assume from your testimony that the pregnancy counseling centers supported by the Christian Action Council are not necessarily looking to receive Federal financial support. However, in your experience are there other pregnancy testing and counseling organizations that offer an alternative that would be interested in title X funding?

Mrs. HAMMOND. I am sure there are. I have had contact with many organizations similar to ours and I believe that they are all organizations that would like to receive title X funding.

We do not support reauthorization of title X as the Christian Action Council, but I am sure there are other centers that would appreciate being able to receive those funds.

Senator DENTON. Your predecessor at the witness table emphasized the necessity for nondirective counseling. I respect his definition in that it included making accessible to the young woman those who are important in her life, including those who have an interest in her fate and in transmitting their own values to her—her parents and those who are responsible for the outcome of whatever sexual involvement she gets into. If it turns out to be a pregnancy, they may have to pay for the upbringing of the child, the abortion, or whatever.

What is your feeling about the possibility that counseling can be nondirective—if there is such a thing? Second, do you think it should be nondirective?

Mrs. **Hammond**. I would say that the women that I saw were in tremendous crisis and for the most part they were being pressured by people, circumstances—the counselor, the medical profession—to make decisions.

I would say that in talking to these women for the most part, they had not met with nondirective counseling from family planning advocates. They had basically been told, abortion is your only option.

Before I worked with the Greater Baltimore Crisis Pregnancy Center, I took two women in to family planning clinics—I was working for the juvenile services administration—and sat there while they were pressured. It was called counseling and they were pressured into aborting.

They were told it is not a baby. It is just a lima bean; it looks like a lima bean. And the other one was told, you are 15; what right do you have to bring a child into this world that you cannot support?

I do not consider that to be counseling, much less nondirective counseling. I believe that it is very important not to say to the woman, this is best for you and you must make this decision. She has to live with the consequences of her actions.

But I believe that the family planning industry has taken a paternalistic view of women—the whole thing of not informing them, not showing them pictures of the fetus to let them know that it has arms, legs.

I have talked with women who turn their heads to see the doctor counting out the little arms and legs and were confronted with it then. It would have been much kinder to show them pictures beforehand.

So I would say that it is a case where women need to have information so that they can make their own decision. I do not know whether you would call that nondirective or directive counseling. I believe in allowing the women to come to their own conclusions, but to give them a lot of information to support their facts, a lot of information about the risks and techniques of abortion and prenatal development.

Senator **Denton**. In all fairness, in making peripheral observations in my own experience, I must acknowledge that I have met women who do not regret having had abortions. I had one woman stop me in an elevator in Birmingham and say, are you not Senator Jeremiah Denton? I said, yes, madam. She said, please do not stop us from having our abortions. So she was not like the 15-year-old girl you referred to.

I have seen Planned Parenthood movies in which young girls perhaps 16, 15 relate in very pleasant terms about their abortions. So there is a difference in opinion. I do not know what that difference in opinion is among those who have had abortions. I do not know how it would sum up. It might be an interesting poll question, but I had to acknowledge that I heard those on the other side.

You discuss three categories of potential clients. In one category you discuss the teenager who has been sexually active for 1 to 2 years, but who does not use contraceptives.

Why do you think some teenagers choose not to use contraceptives? Is it more than a simple lack of access to or lack of information about contraceptives?

Mrs. **Hammond**. Not at all. At our centers we do primarily pregnancy testing; that is one of our primary services, and 90 to 95 percent of the women—we asked them if they were using any contraceptive at the time they think they conceived; 90 to 95 percent responded no.

Senator **Denton**. But were they sufficiently aware of the existence of contraceptives, and the use thereof?

Mrs. **Hammond**. Yes and no. I would say at least 50 percent of those women were aware and had been for some kind of contraceptive counseling. Many of them reported that they had been prescribed different kinds of contraceptives, but chose not to use them.

And I feel very strongly that contraception is not a simple thing. It has far-reaching psychological and social effects upon a woman. I have included a statement; it is actually out of our training manual for volunteers on counseling the client with a negative pregnancy test, talking to her about her sexual involvement.

The thing is that a young teenager when she comes in—it does not even have to be a young teenager; I have met 24-year-olds who are going through this. For the first year or two of being sexually active, they almost always will not choose to use contraceptives.

If you talk to people who are involved in family planning, they will tell you it is their biggest frustration. Family planning was supposed to go out there and stop all these unwanted pregnancies, and they found that the girls themselves will not do it; they just will not, no matter how much information, encouragement, pressure, or whatever. They do not want to use contraceptive devices.

A lot of it, I think, has to do just with their conscience. They know that being sexually involved outside of marriage is wrong; that they are, you know, carrying that with them.

In other words, when they become sexually involved, if they choose to use contraceptives, what they are doing is saying, I am deliberately acting this out; I am deliberately choosing to be sexually involved. If they do not use contraceptives, then what they are basically saying is, it just happened; it was spontaneous; we were in love. And somehow that excuses it.

The other thing is that when a teenager does use contraceptives, it is an irrevocable move into adulthood. She really is passing through a threshold; it is a major life passage for her. And for some medical professional or social worker to say, here, take these pills, have this IUD inserted—it is not that simple.

It is a major life change for her. It is a major decision and it is a large decision, like marriage, like planning a family, like going to college, choosing a career, those kinds of decisions. And it should not be done quickly and easily.

Senator **Denton**. I do agree with you, but there are many who think we have had a sexual revolution and that that is good, and that sexual intercourse before marriage is like a glass of water or a drink, or whatever.

We are at least starting to ask ourselves the question of whether that sexual revolution, which did to a degree exist among many in the sixties and seventies, perhaps—is it good for us? Is it ending?

It is in a goodwill sense of contributing to the promotion of the general welfare and the pursuit of happiness that I see Congress having to play a role in examining the way government is involved in this.

Again, I assert that this is not only in terms of counseling and family planning, but in terms of the way we define or do not define pornography, or how we let PG movies get to the point where they portray usually that the only fun in sex is outside of marriage.

In your opinion, is there a need for research into the human costs of adolescent abortion that span several years after the decision to abort is made?

Mrs. **Hammond**. Definitely. Through my contact with women, and especially teenagers, I have become very aware of what we are beginning to call the postabortion stress syndrome.

The Christian Action Council last spring interviewed in excess of a dozen women from the east and west coasts about their abortion experience. We also interviewed Dr. Sheridan, who is a psychiatrist on the faculty of Georgetown Medical School, who talked about the aftermath of abortion in the women that he has been seeing.

Very little research has been done. It is agreed that the initial response is almost always relief on the part of the woman. But then many women on their due date, on the anniversary of the abortion, possibly 3 years later—one woman that I worked with in Baltimore, 3 years afterwards, had a nervous breakdown. These things need to be studied.

I know that some women say, well, you know, my abortion was fine, but I think that many, many women are suffering acute trauma from it.

Senator **Denton**. May I suggest that you could contribute valuably to the governmental attitude on this were you to try to somehow gather statistics on the results in the lives of those whom you have rendered services to, particularly counseling, and particularly sexuality counseling among those not pregnant. And then they could be compared to the results others use.

That is the only way that we are going to have any firm, comparative data. At this point we will include in the record a statement by Dr. Reed Bell and additional statements and material subsequently supplied the committee for inclusion in the record.

[Additional material supplied for the record follows:]

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TESTIMONY OF
REED BELL, M. D.
BEFORE
THE SUBCOMMITTEE ON FAMILY
AND HUMAN SERVICES
OF THE
SENATE COMMITTEE ON LABOR AND
HUMAN RESOURCES
May 1, 1984

TESTIMONY TO THE UNITED STATES SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

Senate Subcommittee on Family and Human Services

Re: "Reauthorization of Title X of the Public Health Service Act, Population Research and Voluntary Family Planning Programs: Part II."

SD-430, Dirksen Senate Office Building

May 1, 1984 - Tuesday

My name is Dr. Reed Bell and I serve as Medical Director of Sacred Heart Children's Hospital, Pensacola, Florida. I have been teaching and practicing Pediatrics for over 25 years at the community level with special interest in Adolescent Health Care Services.

There is growing and continuing controversy, both public and in professional groups. in restructuring the ethical and legal basis for providing health care services to the adolescent. An analysis and critique of these issues provide a panorama of contrasting and conflicting views regarding the provision of health care services to the adolescent. My viewpoint regarding the psycho-sexual and psycho-social issues which enmesh the public and professionals in the care of this age group comes from a period of active teaching of Pediatrics for over 25 years and the careful study of these issues from a parent and professional viewpoint.

ISSUE IN PERSPECTIVE

Traditionally, the exercise of the rights of consent and confidentiality for the adolescent have been vested in parents acting in the adolescent's behalf. Legal decisions in the specific adolescent health areas of drug abuse, venereal disease, contraception and abortion have awarded legal consent rights to the adolescent while the legal right to confidentiality, i.e., no parental notification, remains at issue.

Proponents of full emancipation, full autonomy of adolescents for health care purposes commend laws regarding consent and confidentiality predicated on three concepts:

1. Pragmatic need;
2. Cognitive development and psycho-social maturation, i.e., The Mature Minor;
3. "New" ethical-legal considerations, i.e., The Minor's Rights Doctrine.

From rhese three concepts, four (4) principles are derived governing issues of consent and confidentiality regarding adolescent health care.

1. Consent Rights: the graduated legal emancipation of minors 12-18 years of age.
2. Confidentiality Rights: health is pre-eminent and no parental consent and/or notification barriers are to be allowed.
3. adolescent assent: the right to affirm parental consent and/or parental notification.
4. an ethical disclaimer: parental assent and/or involvement are desirable and should be encouraged but not legally required.

Since 1973 State and Federal legislative proposals, as well as court decisions have led to full legal rights to consent for the adolescent and the corollary "freedom from liability" for the professional.

Current proposals seek to assure full legal rights of confidentiality, as well, and the removal of all constraints on the adolescent receiving, or the professional providing, health care services to minors aged 12-18 years.[2] Thus, for health care purposes, the "emancipated minor" is created. The adolescent and the professional are freed from any ethical or legal liability as to parental consent, assent and/or notification. This would represent the full emancipation of minors for health care purposes.

Underlying is a basic premise regarding adolescent health care, i.e., parent(s) and families have failed.

By law, no one can exercise the supervision of minors except the parent(s) unless and until the parent(s) has failed. Hence professional surrogate or custodial supervision of minors' health care, i.e., no parental consent or notification, represents an assumption that the parent(s)/family has failed. Therefore, the full legal emancipation of all adolescents is necessary in order to meet their health care needs. The Pediatrician must assume a new "shared" responsibility for providing these services without any ethical or legal constraints.

Opponents of this point of view believe that it is crucial to support parent(s) and the family as the primary caretaker system for children and adolescents until the age of majority. Therefore, they would sustain and protect parent(s)/family rights and responsibilities, legally and ethically, whenever it is available and functioning, in order to meet adolescent health needs. We acknowledge the surrogate parenting role of the professional as clearly applicable to that relatively small percentage of adolescents who suffer parental/family failure or the adolescent is defined as emancipated for particular reasons of law. However, the proposal to expand emancipation to eliminate consent and/or notification of available and functioning parent(s)/family is considered adversarial and not in the long-term best health interest of the overwhelming majority of adolescents.

The current legal consent structure, i.e., state and local law and court precedents, allows the physician-professional adequate protection in providing adolescent health care services, (venereal disease, drug abuse, contraceptive advice, and pregnancy counselling-abortion) when and where it is pragmatically needed. The current legal confidentiality structure, however, places constraints on the adolescent and the physician.

Mr. Hafen's legal essay[4] expresses a growing concern and controversy regarding legal rights for adolescents that have precipitated conflict between two of our most fundamental cultural traditions--family life and individual liberty. He avers that this conflict carries a potential of badly damaging both traditions.

The family tradition historically has enjoyed an important compatibility with the individual tradition because of the family's primary role in preparing children for the responsibility of majority status by helping them develop mature capacities. There are now those who seek to "liberate" children from the captivity of the family tradition. Hence, it is important to examine the relationship of adolescents with family life and individual liberty.

A key concept underlying the policies of protection of minority status is the notion that parents stand in position of authority and responsibility between the state and the child. Short of "in locus parentis" circumstances, parents have been thought to have not only the constitutionally sanctioned right but also the heavy responsibility to protect, educate and influence the values of their children, in addition to providing physical and economic care. The state has had no authority to intervene in those cases unless there was no parent competent to act or parental action threatened serious harm. Children's "liberation" theory states that in no case could parents exercise greater authority than could the state.

I believe there are clarifying distinctions which might help ensure the future compatibility of the family tradition and the individual tradition. The constitutional principles applicable to children can be categorized into rights of "protection" and rights of "choice." No minimal intellectual or other capacity is necessary to justify claim to "protection" rights. "Choice" rights on the other hand are legal authority to make binding decisions of lasting consequence.

An important relationship exists between the "protection-choice" distinction and the concept of minority status. The denial of "choice" rights during minority is a form of protection against the minor's own immaturity and his/her vulnerability to exploitation by those having no lasting responsibility for his/her welfare. Conferring the full-range of "choice" rights, essentially adult legal status, i.e., full emancipation, represents a dissolution of "protection" rights of childhood.

Accordingly, to quote Mr. Brad Hafen, "Supervision of the 'choice' rights of minors is the very heart of the custodial rights of parenthood as well as being the rationale for minority status. For most parents the rights of parenthood leave them no alternative but an assumption of parental responsibility because that responsibility, both by nature and by law, can be assumed by no one else until the parent has failed."

THE ISSUE

Is the parent(s)/family to be deprived of the primary right and primary responsibility for the health care of the adolescent by the state and/or the professional based on the following concepts?

1. PRAGMATIC NEED: Parental involvement constitutes a significant barrier to adolescent health care.
2. MATURE MINOR CONCEPT: Contemporary adolescent cognition and psycho-social maturation provides SELF-AUTONOMOUS decision-making by the adolescent.

3. MINOR'S RIGHTS DOCTRINE: The legal concept of entitlement rights and the "free exercise thereof" from birth.

CRITIQUE OF CONCEPTS

Concept I: Pragmatic Need

The concept of progmatic need is predicated on the recognition that the "rule" of parental consent and/or notification does not apply all the time to all adolescent health care situations. Since health is pre-eminent, all legal and ethical constraints should be eliminated in order to provide needed adolescent health care.

This represents discarding the "rule" or "principle" because there are exceptions, rather than modifying the "rule" in order to address the exception, i.e., the adolescent whose parent(s)/family is failing. The exception (the situation) becomes the "rule."

Hereby, the proponents would asign the adolescent full legal and ethical rights to confidentiality (privacy). The physician would be forbidden from notification of parent(s)/family without adolescent assent. Thereby, the professional would lose the right to notify the parent(s)/family even though this were clearly indicated to be in the best interest of the adolescent's health care.

The ultimate outcome of health care for adolescents remains dependent upon the supportive and supervisory role of the parent(s)/family and only alternatively, on a secondary care-taker or surrogate system. In the overwhelming majority of cases, parent(s)/family are available and functioning, e.g., private Pediatric practice. Where they are not, or the youngster is legally emancipated, the physician-professional and the legal-governmental system (bureaucracy and the courts) meet those needs without parental consent or notification--the surrogate role.

There is no objective evidence that parental involvement (consent and/or notification requirements) constitutes a significant barrier to needed adolescent health care. Neither is there objective evidence that confidential care provides improved health service for the adolescent.

To the contrary, independent access to confidential health care by adolescents may contribute to increasing "controversial" behavior and compromised health care. Empirical? Yes, but one only needs to catalog the increase in "controversial" behavior/health care problems over the past 15 years occurring concurrently with the sexual liberation movement, the demise of personal moral constraints, and the unfulfilled promise of technologic solutions to the problems of premature sexual activity. Certainly it is worth considering the progressive fragmentation of family life over the same period with the loss of parent(s)/family sanctions and the increase in these particular adolescent health problems. These events would seem to warrant efforts to stabilize rather than to undermine the parent(s)/family role and relationship with the adolescent.

For example, the majority of Pediatricians are not willing to break the professional/ethical "contract" with the intact parent(s)/family in order to provide confidential health care services to the adolescent. The professional must retain the right to notify the parent(s)/family if judged to be in the best interest of the adolescent, with or without the adolescent minor's consent or assent. This right and this relationship is to be clearly understood by the adolescent and the parent from the inception of care.

The recommendation of full emancipation may be germane to adolescent care in clinics in areas of high familiar fragmentation and socio-economic dysfunction. It is inappropriate for those serving adolescents of intact families.

There is a need for reasonable legal constraints on the adolescent and the professional providing medical services to adolescents. The constraints on the adolescent, the professional, the bureaucracy and the courts are necessary because there are value-judgments involved, i.e., the social value of the parent(s)/family and the individual rights and responsibilities of adolescents, parent(s), and professionals. In my opinion, the elimination of all constraints (legally emancipate) of the adolescent and/or the professional in instances where the parent(s)/family is available and functional denies basic parental rights and responsibility.

In fact, if the adolescent, the professional, the bureaucracy and the courts are to assume the responsibility for confidential health care service why should they not assume other parental responsibilities, i.e., the adolescent's education, food, clothing, shelter, discipline, etc.? Who is to pay for the services? Who is to assure maintenance and follow-up of "needed" health care services? How would the professional feel is this standard of medical care was applied to his/her adolescent? Can the practice of parental deception remain undiscovered?

Concept 2: The Mature Minor

The premise that adolescents today are more eminently capable than previous generations, especially with professional counsel, in their decision-making, is very doubtful. This is based on "contemporary adolescent cognitive and psycho-social development principles."[3] Most parents and practicing professionals do not share or experience the recognition of this new capability. If anything, the adolescent today may well be the most confused in history, and parents in the vast majority of cases are a lot more capable, responsible and caring in counselling their adolescent decision-maker than proponents of liberation are willing to envisage. Certainly, they will still be around picking up the pieces and putting the youngster back together long after the professional, the bureaucracy and the courts are gone.

A major contention of the proponents of the proposed adolescent full emancipation is the concept of the Mature Minor based on accelerated "cognitive development and psycho-social maturation."[3] At the same time, they acknowledge determination of the minor's maturity is not an easy matter and "rests on a subjective appraisal"[3] b ythe professional health care provider. They concede that young people do need particular guidance and support because of their greater inexperience.

Additional debatable assumptions[3] are made regarding adolescent status and relationships, i.e., (1) the health professional shares the same goals and concerns of the parents; (2) the adolescent is a member of the family but separate; (3) that professionals are ideal role models; and, (4) since parents and family are failing our adolescents, we must insert the critical, extraparental adult, i.e., the professional. The professional is to give guidance and support alledgedly objective, non-judgmental, non-moralizing, to all adolescents with or without parental consent and/or notification, i.e., assume a parental surrogate role.

In point of fact, the logistics of professional practice would not allow for the prolonged contacts necessary to achieve insights into a youngster's complex needs and cultural background. It would be presumtuous for any professional to claim wisdom superior to that of an interested parent in discerning when an adolescent's requests are wise, whimsical, or even self-destructive. Moreover, while it may be presumed that most professionals would be highly motivated in providing health care, this cannot be said for all who seek a role in adolescent counselling. It would be less than wise to presume that every ex-addict drug counselor, every unscrupulous operator of a free-standing abortion clinic, or every predator sex counselor deserves to operate without parental knowledge or consent.

The proponents of the surrogate system presume it to be peculiarly qualified, non-judgmental, non-moralizing and objective in counselling and supervising adolescent choice as to "controversial" behavior and associated health problems, i.e., drug abuse, sex and sexuality, mental and moral health. Whereas, the traditional parent(s)/family relationship and responsibility is deemed clearly unqualified, needlessly judgmental, hopelessly moralistic, and totally subjective.

Indeed and in fact, who is being judgmental? Moralizing? Is the available parent(s)/family to be judged by the adolescent, the professional, the bureaucrat and the court as too subjective, moralistic and unable to act appropriately in the long-term best interest of the youngster?

Concept 3: The Minor's Rights Doctrine

The legal concept of the child or minor's rights perspective is the foundation of the minor's rights doctrine. In particular, the newfound "Right to Privacy" of children represents new legal approaches to all minors based on "Entitlement Rights" and the free exercise thereof from birth. This movement constitutes an effort to liberate children and adolescents and represents a major departure from legal, ethical and cultural tradition. As such, it must not be merely asserted but rather demonstrated to be superior to tested safeguards.

On this basis, adolescents continue to be provided the notion that their appetites and desires represent a need and, hence, they are "entitled," i.e., have the right to fulfill or actualize self--be sexually active, use drugs, etc. All of this is based on the premise of sexual rights and the right to self-expression because there is no defined morality to sexuality or self-expression, i.e., an amoral, value-free, liberated society. The fact is that these "rights" vitally concern individual responsibility and, therefore, warrant ethical and legal constraints on their exercise. Indeed, it is not merely a matter of choice, any choice, and simply justifying that choice only to self, i.e., SELF-AUTONOMY. Youngsters 12-18 years of age do choose self-injury, autonomously. They need concrete "rights" and "wrongs" to limit them until they are mature enough to make a "good" choice, not just any choice. The immature, inexperienced, vulnerable adolescent needs moral guidance by parent(s)/family. There are "rights" and "wrongs" to be defined which are in the best interest of the adolescent and should be judged as such by the professional, as well as, by the parent(s)/family. The responsibility is not only to self (privacy) but to others, i.e., parent(s)/family, society, etc.

The behaviors involved in adolescent health care are labeled "controversial." This under-statement is the crux of the conflict evolving between parent(s)/family and the professional providing health care to the adolescent. Premature sexually active behavior with its concomitant health care problems of venereal disease, contraception and abortion, and the often associated drug scene are moral issues and therefore require mature judgment. Whose judgment? Whose morality?

The professional proponents insist that the issue of "controversial" behavior and its concomitant health care problems are simply a matter of legal emancipation of the adolescent and the liability emancipation of the professional regarding consent and confidentiality. Inherent in these proposals are the moral emancipation of all involved, while imposing legal constraints on the parent(s)/family abrogating their rights and responsibilities.

Parents do not have absolute or sovereign "rights" over their children. There is a need for reasonable legal constraints on parent(s)/family. For example, issues involving child abuse. Where is the balance? What are the appropriate limits? Limits, not only for parent(s)/family, but constraints on adolescents, professionals, bureaucracy and the adversarial system, i.e., the law. For sure, the statement of faith in professionals and the adversary, objective, legal system superceding the necessary legal and ethical commitment to parents and the family as advocacy system is clearly debatable.

IMPLICATIONS: VIEWPOINT

Should we really feel that the professional is the key to the long-term health care of the majority of adolescents that have intact parent(s)/family? Is the law and the professional, sharing and supporting the adolescent in his autonomous decision-making, the answer to adolescent health needs? Certainly that is true where parent(s)/family are absent or dysfunctional or the youngster is legally emancipated for specific reasons of law, but not just because the adolescent or his professional surrogate desire no constraints, no value judgment, no moralizing. Why are the professionals and the courts willing to be quite judgmental of the parent(s)/family but unwilling to be judgmental of the adolescent regarding his obligations? Is the adolescent to act responsibly but yet not have concretely defined limits or constraints (ethical or legal) regarding his choice, even if that choice constitutes self-injury and irresponsibility? Personal moral constraint and family-based sanctions are the primary restraints remaining in remedicting irresponsible behavior.

The social services professionals lead the way for us by educating professionals to confront parents who abuse their children and define the treatment ideal of supporting and stabilizing the abusing family. Can we do less than caringly confront minors regarding their self-injury? If we judge and moralize regarding parents, why not minors? Hereby the professional responsibilities are in accord with the parents in the context of their family.

The moral confrontation implicit in the above critique is caring in its deepest sense. The professional's primary role and responsibility is as a facilitator to insure communication of the adolescent and parent(s)/family. That is what they both desire and desperately need. Modern parent(s)/family can "hack it" if given help and support.

Perhaps we should also confront the primary cause of the problems of teenage sexuality, i.e., the shattered network of communications among parent(s)/family and their children which is responsible for increased premature sexual activity and attendent health problems. Technological measures and professional counselling only suppress the results. As Eunice Kennedy Shriver opined, "If we do not involve our teenagers in moral discourse, if we do not strengthen families, if we do not add a dimension of responsibility and control to sexuality, if we do not care for those who become pregnant, if we can do no more than propose technological solutions to an issue that concerns human life--what does that say about us?"

CONCLUSION

The proponents for full emancipation of adolescents for health care service base their case on the false premise that parent(s) and families have failed. Only "some" have failed!

The principles enunciated of full legal and ethical emancipation of all adolescents, minors ages 12-18, regarding health care is neither valid nor in the best interest of adolescents who have available and functioning parent(s)/ family.

Full Emancipation of adolescents for health care purposes is appropriate when there is parental/family failure or the adolescent is defined as emancipated for specific reasons of law.

There is no adequate evidente that the three concepts of Pragmatic Need, the Mature Minor and the Minor's Rights Doctrine, from which the principle of Full Emancipation is derived, are valid. Furthermore, there is no objective evidence that these concepts and principles regarding consent and confidentiality issues would assure improved health care for children and adolescents.

The statement that "health is pre-eminent"[1] is questionable. There are many facets to the notion of health, particularly in the areas addressed, that involve personal, social and cultural values, i.e. human behavior. There is much more importance to the human relationships involved in the health care of adolescents than simple license, i.e., full moral, ethical and legal emancipation.

The differences expressed notably relate to shared goals and concerns regarding adolescent health. Both viewpoints cherish the goals of healthy, mature, coping, responsible adults, in turn assuring their progeny the same maturity in a just and caring society. The differences, however, are profound as to the means to those ends.

The proposed emancipation, the liberation of adolescents earlier from their parental/family responsibility and moral values, is not the best means for assuring these shared goals. There is a vital need to support the present constraints on the adolescent, the professional, the bureaucracy and the courts in behalf of the adolescent's need to become mature, responsible in the protective environs of the primary caretaker, i.e., the parent(s)/family unit. Primary Prevention, i.e., the ideals of responsible (moral) behavior, is necessary for adolescent health care and their achievement of maturity and independent, responsible, freedom, earned as a citizen's right and not simply as an Entitlement.

PROPOSAL

I would like to recommend consideration of the following approach to adolescent health care by the professional as a positive alternative.

An ethical agreement, an oral "contract," is to be reached with the parent and adolescent prior to provision of health services. Such agreements are applicable to public clinics as well as private practice under responsible professional supervision.

The principles of the agreement are as follows:

Parental consent and notification is in the best interest of the adolescent when the parent(s)/family are available and functioning. Therefore, the professional, should maintain the right of parental consent and notification, preferably, but not necessarily, with the adolescent's assent.

Parental consent and notification is not in the best interest of the adolescent when there is parent(s)/family failure or the adolescent is emancipated for specific reasons of law.

Thus, exceptions to the general principle of parental consent and notification may be justified by a reasonable responsible exercise of the professional's judgment in the best interest of the adolescent.

Assuming available and functioning parent(s)/family, the specifics of this agreement are as follows:

Sexual abstinence is commended as the ideal for the adolescent.

Non-prescriptive, publicly available barrier/chemical methods of contraception are safe, effective, inexpensive, accessible, readily utilized and afford adequate contraception when abstinence is rejected. Parental consent and/or confidentiality are not at issue.

Prescribed contraception, i.e., the IUD and the "pill," and abortion involve potential serious harm and risk for the adolescent and, therefore, warrant parental consent and notification.

The management of substance abuse in the adolescent is peculiarly dependent upon parent(s)/family involvement and warrants parental notification.

The treatment of venereal disease is a pragmatic need and, as a public health interest, warrants confidentiality or adolescent assent to parental notification.

Conversely, in the circumstance of parent(s)/family failure, the professional may proceed with informed consent of the adolescent and act in the best interest of the adolescent as follows:

Abstinence remains a suitable ideal to be proffered. Barrier/chemical contraception is counselled. Prescribed contraception, i.e., the IUD and the "pill," is an option which involves potential for serious harm and risk that does not require consent but warrants parent(s)/family notification. In my opinion, the abortion option requires parent(s)/family consent and notification. Substance abuse and venereal disease are treated without parent(s)/

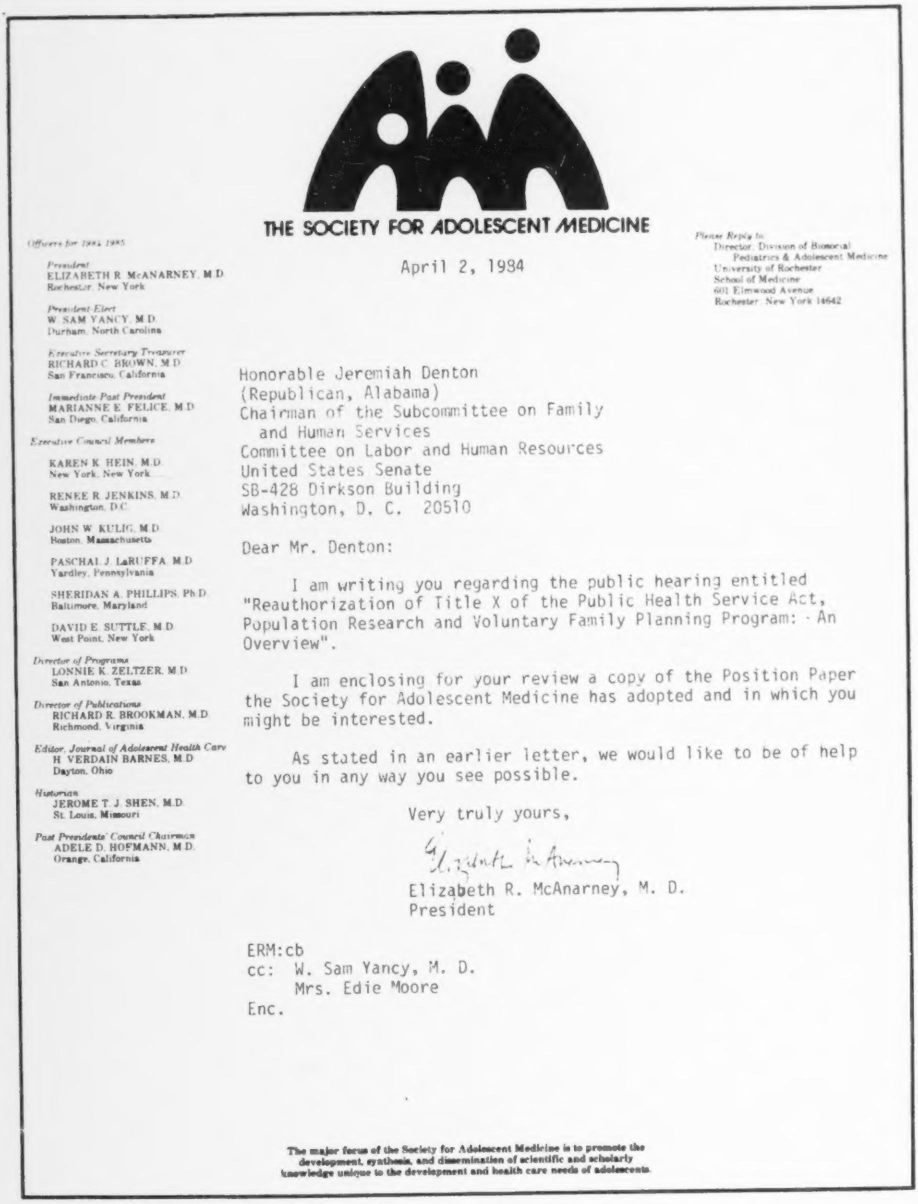
family consent and notification is exercised only with adolescent assent. Summary Table I.

TABLE I

	Functional Parent(s)/Family		Failed Parent(s)/Family	
Health Care:	Consent	Notification	Consent	Notification
Prescribed Contraception	Yes	Yes	No	Yes
Abortion	Yes	Yes	Yes	Yes
Substance Abuse	No	Yes	No	No
Venereal Disease	No	No	No	No

The risk of suit by the parent(s)/family reasonably judged to have failed, or when the adolescent is emancipated for specific reasons of law, is essentially nil based on case law.

The adolescent, however, has the right to sue in many jurisdictions for a period of two (2) years after maturity, usually until age 23. Therefore, professional liability requires a regard for litigation when harm ensues from medical risk procedures (IUD, "pill," abortion) in the adolescent as with any other patient, whether or not parental consent and notification is obtained.



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April 2, 1984

Honorable Jeremiah Denton
(Republican, Alabama)
Chairman of the Subcommittee on Family
and Human Services
Committee on Labor and Human Resources
United States Senate
SB-428 Dirkson Building
Washington, D. C. 20510

Dear Mr. Denton:

I am writing you regarding the public hearing entitled "Reauthorization of Title X of the Public Health Service Act, Population Research and Voluntary Family Planning Program: An Overview".

I am enclosing for your review a copy of the Position Paper the Society for Adolescent Medicine has adopted and in which you might be interested.

As stated in an earlier letter, we would like to be of help to you in any way you see possible.

Very truly yours,

Elizabeth R. McAnarney, M. D.
President

ERM:cb
cc: W. Sam Yancy, M. D.
Mrs. Edie Moore
Enc.

The major focus of the Society for Adolescent Medicine is to promote the development, synthesis, and dissemination of scientific and scholarly knowledge unique to the development and health care needs of adolescents.

JOURNAL OF ADOLESCENT HEALTH CARE 1983;4:205–10

Position Papers on Reproductive Health Care for Adolescents

SOCIETY FOR ADOLESCENT MEDICINE

Introduction

Sexuality is an integral, multifaceted part of being human; reproduction represents only one aspect of human sexuality. Most of our professional attention in the past has focused on the reproductive adolescent instead of the sexual child, adolescent, and adult. Our professional focus has been directed primarily toward disease prevention, rather than health promotion. The reproductive health needs of adolescents are best served through a broad approach to sexuality as a life-long responsibility of the individual. This is nurtured by promoting the availability and delivery of excellent medical services and health education programs directed toward general and psychosexual adolescent development.

In this position paper, we shall present pertinent background data and briefly discuss three major, current challenges. We shall then state the position of the Society for Adolescent Medicine on adolescent sexuality, sex education, contraception, adolescent childbearing and childrearing, abortion, and sexually transmitted diseases.

Background Data

Adolescent pregnancy[*] remains a problem of major proportion in the United States. Recent data indicate that adolescents and their infants do equally as well as adults perinatally if there is adequate and consistent prenatal care [1,2]; many pregnant adolescents still do not receive such care and thus are medically at high risk. The young adolescent who bears a child is likely to repeat pregnancy during adolescence and to have increased medical risk with subsequent pregnancies. At any age, she is likely to remain a single parent or to experience unsuccessful marriage. Both she and her male partner ultimately receive fewer years of formal education and vocational opportunities than adults who have not become adolescent parents [3,4].

Despite a relative increase in the number of adolescents who use contraception, pregnancy rates remain high, even though the birth-rate has decreased in recent years, largely due to the increased availability of abortion services. In 1970, women less than 20 years of age bore 656,460 children, the largest number in recent years. In 1978, by contrast there were 554,179 births to adolescents (10,772 to 12–14-year-olds; 202,661 to 15–17-year-olds; 340,746 to 18–19-year-olds) [5,6].

The most dramatic recent change in fertility statistics has not been in births, but in abortions. The number performed on teenagers has increased yearly since the procedure became legalized nationwide in 1973. In 1978, there were 357,028 teenage abortions (12,754 for 12–14-year-olds; 139,156 for 15–17-year-olds; 205,118 for 18–19-year-olds). The numbers and

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[*] The focus of this position paper is the reproductive health care of the adolescent who has not yet reached legal majority and/or who is biologically, cognitively, and/or psychosocially immature. "Adolescent pregnancy" refers to conception occurring in adolescents who are cognitively, emotionally, and/or legally immature. It encompasses those-becoming pregnant before 13 years of age as well as those who are 18 years old or older who have not completed the process of adolescence. Our concerns apply to adolescent males as well as females, those who are married as well as unmarried, and those who already are parents. The assumption is made that the earlier conception occurs in an adolescent's life, the more likely it is to be associated with negative sequelae for the youth and offspring and this risk is not lessened by marriage.

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rate of abortion have stayed relatively stable since 1975 for those less than 15 years of age.

The abortion ratio (abortions/1000 live births) provides a good indicator of the percentage of unplanned pregnancies. In 1978 there were 644 abortions for every 1000 live births to teenagers overall (1183 for 12–14-year-olds; 687 for 15–17-year-olds; 602 for 18–19-year-olds). Abortion is not without morbidity, especially for the adolescent who frequently delays the procedure until later in gestation [7].

Most health professionals agree that abortion should not be a form of birth control. Therefore, prevention of unwanted pregnancy must be stressed. This is especially true since between 1976 and 1979, the percentage of 15–19-year-old, never-married women who reported they ever had premarital intercourse increased from 43.4% to 49.8%. Of males 17–21 years of age 70.3% reported having had premarital intercourse according to 1980 report by Zelnik and Kantner [8].

Even though there has been considerable improvement in the use of contraception by sexually experienced, never-married adolescent women (from 45% at last intercourse in 1971 to 63% in 1976 in one study), adolescents as a group are still less-than-effective contraceptors. Between 1971 and 1976, the percentage of adolescents who never used contraceptives increased from 17% to 26% [9]. Zelnik and Kantner have noted a decrease over time in the utilization of effective methods such as oral contraceptives or intrauterine devices and an increased utilization of less-effective methods such as withdrawal and rhythm [8].

The rhythm method, for example, requires a regular menstrual cycle and the teenager's knowledge of her ovulatory cycle. Adolescents often have neither. One large survey found that only 37% of 15–17-year-old females and 49% of 18–19-year-old females knew the time in the cycle of greatest fertility. Having had a sex education course did seem to make a difference in this knowledge, especially among the younger women. Only 27% of the 15–17-year-olds who did not have a sex education course knew the time of greatest risk, compared with 41% of those who did have such a course [10].

Conception is but one potentially harmful consequence of adolescent sexual activity. Sexually transmitted diseases increasingly threaten the health and well-being of millions of adolescents. Males and females between the ages of 15 and 24 years of age account for about 75% of all reported cases. More important, an estimated 75,000 women of childbearing age become sterile each year as a result of pelvic inflammatory disease caused by sexually transmitted infection [11]. There is also reason for concern about future neoplasia in the sexually active female adolescent. Women taking oral contraceptives [12], women using no contraceptives [13], even women whose partners use condoms consistently [14], all appear to have an increased risk of developing a gynecologic neoplasm compared to virgins [7]. This risk is increased with earlier age of first sexual intercourse, with frequency of intercourse, with number of partners, and with number of endocervical infections.

A more difficult to study consequence of premature sexual activity is the associated psychological morbidity. Cvetkovich and Grote [15] suggest that persons who remain virginal during adolescence formulate their gender identity at an earlier age than nonvirgins. They also note that the sexually active group of adolescents whom they studied appeared "to be liberal, but not liberated." Many research questions still need to be answered. For example is social immaturity a cause, or a consequence, of adolescent sexual activity? Can sexual assertiveness training result in more positive consequences and responsible sexual behavior [16]?

Based on reviewing the decade of the 1970s, we face several dilemmas: More adolescents are sexually active; a substantial number become pregnant; fewer in actual numbers bear children, but a substantial number have abortions; more unmarried adolescent women use contraception but are more likely to use less-effective methods; and a substantial number still do not know when in the menstrual cycle a woman is most likely to become pregnant.

Health providers face immense challenges with regard to adolescent reproductive health. We have chosen three issues of particularly pressing concern to emphasize the scope of these challenges (parental notification, sex education, and the adolescent father.)

Current Challenges

Parental Notification

More than 50% of adolescents currently involve parents in the decision to seek contraception or to have abortions, or both, according to a recent survey [17]. Of adolescents attending family planning clinics, 55% stated that their parents knew. When the 45% of teens whose parents did not know were asked what they would do if parental consent were required, more than one-half said they would stop attending. Of these, the majority would change to nonprescription methods. Only 2% of the total said they would stop having sex. Studies show that services requiring parental consent for adolescents tend to provide less care to teens than services lacking such requirements. Thus, adolescents are more likely to obtain necessary medical services if they are not forced to obtain parental consent, although many will voluntarily discuss this issue with parents [18]. Many services today strongly encourage, but do not require parental involvement. This is a more acceptable, and undoubtedly more effective policy in maximizing the number of youth who will be served.

Legal requirements of parental consent, consultation, or notifications suggest that adolescents are unwilling to talk with their families and that parents will not participate in their children's decisions unless required by law—a situation far removed from truth in most cases. Health professionals need the flexibility to make individual judgements about the best interests of adolescents and their families. Some adolescents must be assured of confidentiality in the patient–professional relationship if they are to seek medical assistance at all and not forego, or withdraw from, needed care. Legal requirements to involve parents in all cases, however well-intentioned, not only are unnecessary but are potentially detrimental. They can result in increased rather than decreased rates of unintended pregnancy and out-of-wedlock childbearing or abortion. They risk increasing the medical complications of abortions and unwanted births to adolescents by delaying the receipt of services through fear of disclosure. In some cases, forced and possibly premature involvement of the parents may promote irreparable fracture of the family unit, the very consequence proponents of mandatory parental involvement seek to prevent.

Implicit in this argument is an acknowledgement of a minor's right to consent to reproductive health care as determined by his or her level of maturity. Otherwise, as noted by Hoffman, "parents, adolescents and health providers become adversaries and the unique developmental status of the adolescent is overlooked, i.e., he is treated inappropriately either as a dependent child or as a wholly autonomous adult during his emancipation" [19].

Once one acknowledges the right of an adolescent to reproductive health care, "who will pay" must be addressed. At present, there is no universally acceptable response to this question because prepaid health plans and free clinics are available to only a minority of adolescents.

Sex Education

Sex education appears to improve adolescents' sexual knowledge, but many questions remain about whether sex education alters sexual responsibility. Historically, it is believed that adolescents should be taught about fertility, contraception, sexually transmitted diseases, sexuality, and parenthood, and that with this knowledge their behavior will be modified toward greater responsibility. There are no data to either prove or disprove this assumption.

Concerns are often voiced that discussing sexuality with adolescents only encourages sexual activity. Most sex education research has found that increasing an adolescent's sexual knowledge does not increase his or her sexual activity [20]. Further, on their own, adolescents tend to obtain sexual information, although often inaccurate and from unreliable sources [21].

Reliable sex education in the schools and at home presently may be a utopian goal. One study found that 98% of parents reported needing help in talking to their teenage children about sex [22]. Another study revealed that only 45% of the mothers questioned knew the fertile period of their menstrual cycles, and only 18% realized that intercourse 2 days after ovulation could lead to pregnancy [22].

Although parents need to be involved in the sexual training of their adolescents, parents themselves need to become knowledgeable in sexual matters. A family life program in San Bernardino, California has been established to provide such education, enabling parents to consider their teenager's sexuality [23]. In support of such programs is the finding by Lewis that "rather than stimulate coital experimentation, sex information given primarily by parents seems to contribute to more restrictive premarital sexual behavior" [24].

As of 1978, only three states (Kentucky, Maryland, and New Jersey) and the District of Columbia require sex education in the schools. Another seven states (Minnesota, Iowa, Illinois, Pennsylvania, Delaware, Utah, and Kansas) encourage sex education; the latter two states discourage the discussion of birth control in sex education classes, however. Thus, approximately 80% of our junior and senior high age youth live in states where the decision to offer family life and sex education is left to the jurisdiction of the local school district [25]. This is clearly unacceptable if we are to enhance the awareness of all our youth. In addition, sex education within the schools does not reach those youth who have dropped out or who are truant frequently.

One national survey of high school principals in 1978 found that only 36% of high schools offered a separate sex education course. Much instruction on sexuality and reproduction takes place only in the context of health or biology classes. One must question the effectiveness of all this instruction in light of some of the previously discussed data.

The Adolescent Father

The welfare of the unmarried adolescent father and his importance in decisions regarding the outcome of the pregnancy are significant but often neglected issues. As suggested by Pannor and others, the active involvement of the male partner can be of considerable emotional benefit to the pregnant teenager [26]. There is still insufficient information regarding the psychosocial morbidity the teenage male suffers for fathering an unwanted child.

There is similar need to study the adolescent male who is not yet a father, as well as the adolescent male who has not become sexually active. As pointed out in the study by Cvetkovich and Grote, the three groups—fathers, sexually active nonfathers, and virgins—may differ sufficiently with respect to variables such as self-concept, sex-role concepts, family orientation, and religious orientation to permit identification of important determinants of responsible sexual behavior by a systematic examination of various components of sexual as well as nonsexual identity.

Summary

There are no simple solutions to the problems associated with adolescent sexual activity. As a Society dedicated to "promoting the development, synthesis, and dissemination of scientific and scholarly knowledge unique to developmental and health care needs of adolescents," we encourage continued scientific focus on the issues related to adolescent reproduction. The positions of the Society of Adolescent Medicine on reproductive health care for adolescents follow and represent the views of the membership. Obviously, unanimous concurrence on such sensitive issues is impossible and the differing opinions by some of the membership are recognized and respected.

The Ad Hoc Committee on Reproductive Health
Richard E. Kreipe, M.D.
Catherine MacDonald, M.D.
Elizabeth R. McAnarney, M.D., *Chairman*

The Committee would like to extend its gratitude for Adele D. Hofmann, M.D. who assisted the Committee in the final wording of the Position Statements.

Positions Papers on Reproductive Health Care for Adolescents

Adolescent Sexuality

The Society for Adolescent Medicine hereby resolves to support and encourage the development of responsibility toward sexuality on the part of all adolescents; to support and encourage an awareness and acceptance by adults of sexuality in all children and adolescents; and to support and encourage an approach to adolescent reproductive health care that promotes health as well as prevents disease.

Sex Education

The Society for Adolescent Medicine hereby resolves that all States should mandate the teaching of Health and Sex Education from kindergarten through the

12th grade, as part of the overall curriculum in schools; that the content of this education should include discussions of sexuality, reproduction, fertility, contraception, abortion, parenting, and sexually transmitted diseases; that school personnel responsible for teaching health and sex education should have proper training in the biological, psychological, and moral aspects of human sexuality; and that parents should be integrally involved in the development and implementation of the sex education curriculum planned for their children.

Contraception

The Society for Adolescent Medicine hereby resolves that contraceptive education, counseling, and services should be made available to all male and female adolescents desiring such education, counseling and services on the adolescents' own consent without legal or financial barriers. While parental involvement should be encouraged, this should not be required through either consent or notification mandates.

Adolescent Childbearing and Childrearing

The Society for Adolescent Medicine hereby resolves that pregnancy detection and subsequent prenatal health, counseling, educational and postnatal services (including child care), should be available and accessible to adolescents who choose to continue their pregnancies, without legal or financial barriers. These services should be extended to include the adolescent's partner and family, if she desires, and should include counseling on adoption and/or parenting. There should be increased interest in studying the role and needs of the teenaged father and in providing services even when there will not be a continuing relationship with the teenaged mother or the offspring.

Abortion

The Society for Adolescent Medicine hereby resolves that medical abortion should remain a legal, available alternative to continuing a pregnancy; that the adolescent should have freedom of access to abortion services without legal and financial barriers; and that the decision to terminate a pregnancy should rest with the pregnant adolescent in concert with the advice and counsel of her physician. While the involvement of significant others should be strongly encouraged, particularly for immature and still dependent minors, mandatory parental consent and/or notification should not be required. Moreover, when determination of maturity is necessary, that determination is best made by a knowledgeable health professional.

Sexually Transmitted Diseases

The Society for Adolescent Medicine hereby resolves that no barriers should prevent adolescents from obtaining timely education, counseling, and/or health services for the prevention, diagnosis or treatment of sexually transmitted diseases; and that minors should have access to such education, counseling and health services on their own consent without the requirement of either mandatory parental consent or parental notification.

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Dear Christe Arbuckle:

Please do not use Title X funds for Planned Parenthood

Thank you.

Mrs Connie Benge
275 Drake Lane
Des Plaines, Illinois
60016

4-24-84

Christi Arbuckle
Office Manager
Subcommittee on Family & Human Services
U.S. Senate
Rm. SD-428
Dirksen Office Building
Washington D.C. 20510

Dear Christi Arbuckle,

We are writing to ask that money should not be given to Planned Parenthood from the Title X Fund

We feel that Planned Parenthood promotes itself by giving contraceptives to teens & adults. They also promote abortion as a back up to contraceptive failure. Because of this, they are helping to disrupt many families.

Sincerely,

Mr. & Mrs. Richard Pender

April 26, 1984

Mr. Christi Arbuckle,
Office Manager,
Subcommittee on Family & Human Services
U. S. Senate, Rm. SD-428
Dirkson Office Bldg.
Washington, D. C. 20510

Dear Sir:

I would like to request that Title X funds do not be granted to Planned Parenthood.

Very truly yours,

Mrs James Windgassen

Mrs. James Windgassen
134 So. Deerpath Rd.
Barrington, Il. 60010

April 27, 1984

I can't believe we're still funding Planned Parenthood. No more! No Title X funds to Planned Parenthood!

Sincerely,
Joan Medina

Mrs. Robert F. Medina
2870 Cherokee Lane
Riverwoods, IL 60015

MR. & MRS. ALBERT C. GEIMER
AND FAMILY
7943 NORTH LOWELL AVENUE
SKOKIE, ILLINOIS 60076

May 7, 1984

Christi Arbuckle
Office Manager
Subcommittee on Family & Human Services
United States Senate
Room SD-428
Dirkson Office Building
Washington, D. C. 20510

Dear Christi Arbuckle,

I am writing to ask that Title X funds not be given to Planned Parenthood. The organization is not using the funds properly.

Planned Parenthood claims that they are interested in flamily planning. However, although many of us parents desire large families, they spend almost all of their efforts in promoting abortions. This is a violation of the 1973 Supreme Court ruling that mandates that expectant mothers be educated about all alternatives of pregnancy.

The Courts have ruled over and over that the mother has the sole right to make a decision about her child. Therefore, Planned Parenthood is remiss in not explaining about the risks of abortion, the possibilities of adoption and governmental assistance that is available to help raise their children.

Sincerely,

Albert C. Geimer

Albert C. Geimer

May 10, 1984

From: Paul E. Beisch
5500 Washington St.
Morton Grove, IL 60053

To: Christi Arbuckle
Office Manager
Subcommittee on Family and Human Services
U. S. Senate
Rm. SD-428
Dirkson Office Building
Washington, D.C. 20510

Dear Mam:

Title X funds should not be given to Planned Parenthood as it is the leading promoter of abortion. Over 100,000 abortions are done annually in clinics owned by Planned Parenthood.[1]

The Pill and IUD which are abortificant, are pushed by the Planned Parenthood clinics.[2] A fertilized egg is not allowed to be implanted with the IUD and Pill according to the FDA.

Sincerely,

Paul E. Beisch

Paul E. Beisch

[1] Catholics United for Life, "The New Paganism" Catholics United for Life, New Hope, KY 40052, 1978

[2] Ibid.

Christi Arbuckle
Office Manager
Subcommittee on Family and Human Services
United States Senate
Room SD-428 Dirkson Office Bldg.
Washington D. C. 20510

Dear Ms. Arbuckle,

I am writing in regards to Title X funds and your part in directing these funds. I do not want to see any funding granted to Planned Parenthood. I am in disagreement with their actions concerning abortions. I do not feel that they should receive any money from Title X. As a major promoter of abortions, Planned Parenthood lends only to the problems each person and family must face in this day and age. Again I urge you not to allow any Title X funds be granted to this organization. Thank you for your consideration.

Sincerely, Barbara A. Cripe
Barbara A. Cripe
33 Laurel Tr.
Wheeling, Il. 60090

May 1, 1984

Christi Arbuckle, Office Manager
Family & Human Services
Washington, DC

I am requesting that Title 4 funds are not granted to Planned Parenthood. I strongly object to this anti-family - anti-youth organization continues to receive funds from my taxes!

M M Cook
1154 Cedarwood Ct
Elk Grove Vlg, IL
60007

Senator **Denton**. I would like to thank you very much, Mrs. Hammond, and thank all of our witnesses for taking part in this hearing to consider the reauthorization of the title X program. This hearing stands adjourned.

[Whereupon, at 11:52 a.m., the subcommittee was adjourned.]

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